DOCUMENT RESUME

ED 475 653 PS 031 204

AUTHOR	VanLandeghem, Karen
TITLE	Children's Mental Health: An Urgent Priority for Illinois. Final Report.
INSTITUTION	Voices for Illinois Children, Chicago.
PUB DATE	2003-04-00
NOTE	54p.; Financial support provided by the Illinois Violence Prevention Authority and the Irving B. Harris Foundation.
AVAILABLE FROM	Voices for Illinois Children, 208 S. LaSalle Street, Suite 1490, Chicago, IL 60604-1103. Tel: 312-456-0600; Fax: 312-456-0088; e-mail: info@voices4kids.org; Web site: http://www.voices4kids.org. For full text: http://www.voices4kids.org/ mentalhealth0403.pdf.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	EDRS Price MF01/PC03 Plus Postage.
DESCRIPTORS	Access to Health Care; Agency Cooperation; Change Strategies; *Childhood Needs; *Children; Early Intervention; Financial Support; *Mental Health; Objectives; Prevention; Program Descriptions; *Program Improvement; State Programs; Well Being
IDENTIFIERS	*Illinois

ABSTRACT

The Illinois Children's Mental Health Task Force was convened in 2002 to assess the status of Illinois' mental health system for children from birth to age 18, and to develop short- and long-term recommendations for assuring that all Illinois children have access to coordinated and comprehensive mental health services and programs. This report is the culmination of several months of Task Force and committee work examining research and policy studies, identifying key goals and recommendations, and deliberating about the priority areas most needed in Illinois. The report also serves as a blueprint for constructing a new system of children's mental health services in the state. Following an introduction, the report outlines a vision for children's mental health in Illinois, highlights children's mental health facts, and discusses barriers and opportunities for a comprehensive children's mental health system. The report concludes with detailed task force recommendations: (1) make children's mental health a priority; (2) develop and strengthen prevention, early intervention, and treatment policies, programs, and services for all children; (3) maximize current investments and invest sufficient fiscal resources over time; (4) build a qualified and adequately trained workforce with sufficient number of professionals to serve children and their families; (5) increase public education and awareness; (6) create a quality-driven children's mental health system with shared accountability among key state agencies and programs; and (7) invest in research. An annotated list of public systems, services, and programs that serve Illinois children is appended. (Lists 21 federal/national and 8 state mental health resources. Contains 23 endnotes.) (HTH)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 475 653

CHILDREN'S MENTAL HEALTH: AN URGENT PRIORITY FOR ILLINOIS

Final Report
Illinois Children's Mental Health Task Force

APRIL 2003

BEST COPY AVAILABLE

PS 031204

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
X This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY
Julie Zasadny
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Members of the Illinois Children's Mental Health Task Force

Task Force Chair

Barbara Shaw	*Illinois Violence Prevention Authority*

Task Force Co-Chairs

Sue Gamm	*Chicago Public Schools*
Gaylord Gieseke	*Voices for Illinois Children*
Jan Holcomb	*Mental Health Association in Illinois*

Committee Co-Chairs

Early Childhood Committee

Karen Freel	*Ounce of Prevention Fund*
Gaylord Gieseke	*Voices for Illinois Children*

School-Age Committee

Terry Carmichael	*Community Behavioral Health Care Association of Illinois*
Sue Gamm	*Chicago Public Schools*

Policy/Resources Committee

Jan Holcomb	*Mental Health Association in Illinois*
Maria McCabe	*Illinois School Counselors Association*

Executive Committee

Terry Carmichael	*Community Behavioral Health Care Association of Illinois*
Karen Freel	*Ounce of Prevention Fund*
Sue Gamm	*Chicago Public Schools*
Gaylord Gieseke	*Voices for Illinois Children*
Jan Holcomb	*Mental Health Association in Illinois*
Carolyn Cochran Kopel	*Illinois Department of Human Services*
Maria McCabe	*Illinois School Counselors Association*
William Schwartz	*Office of the Attorney General*
Barbara Shaw	*Illinois Violence Prevention Authority*
Karen VanLandeghem	*Consultant*
Velma Williams	*Illinois Department of Children and Family Services*

Task Force Members

Howard Adelman	*University of California at Los Angeles*
Chris Ahlman	*Illinois School Social Workers Association*
Frank Anselmo	*Community Behavioral Health Care Association of Illinois*
Shelley Banks	*Illinois Office of the Attorney General*
Carl Bell	*Community Mental Health Council*
Patricia R. Bellock	*Illinois General Assembly*
Karen Berg	*Illinois Coalition for School Health Centers*
Marge Berglind	*Child Care Association of Illinois*
Heidi Biedermann	*Large Unit District Association*
Debbie Bretag	*Illinois Center for Violence Prevention*
Carol Brigman	*Illinois Department of Human Services*
Ruth Brown	*Illinois State Board of Education*
Paula Casas	*Ounce of Prevention Fund*
Betsy Clarke	*Juvenile Justice Initiative*
Elizabeth Coulson	*Illinois General Assembly*
Caryn Curry	*Mental Health Association in Illinois*
Anthony D'Agostino	*Illinois Psychiatric Society*
Antonio Delgado	*Office of the Mayor*
Linda Delimata	*Illinois Counseling Association*
Eric Dockery	*Chicago Public Schools*
James F. Dougherty	*Illinois Federation of Teachers*
Lucille Eber	*Illinois State Board of Education*
Claudia Fabian	*Migrant Head Start*
Kimberly Fitzgerald	*Voices for Illinois Children*
Everardo Franco	*National Center for Latinos with Disabilities*
Andrea Goss	*Illinois Department of Children and Family Services*
Martha Gottlieb	*Cook County Bureau of Health Services*
Julie Hamos	*Illinois General Assembly*
Lynn Handy	*Illinois Department of Public Aid*
Mike Havey	*Illinois School Psychologists Association*
Mark Hilliard	*Illinois Department of Public Health*
Elaine Hoff	*Illinois Office of the Attorney General*
Mark Holzberg	*Illinois Department of Children and Family Services*
Annette Johnson	*Chicago Public Schools*
Deborah Kennedy	*Equip for Equality*
Joseph Kim	*Illinois Office of the Governor*
Jane Knitzer	*Columbia University*
Marsha Koelliker	*Equip for Equality*
Terrence Koller	*Illinois Psychological Association*
Louis T. Lang	*Illinois General Assembly*
Dian Ledbetter	*Illinois Federation of Families*
Cathy Leonis	*Illinois Department of Public Aid*
Michael Litow	*The Education Center*
Barb Maier	*National Alliance for the Mentally Ill*
Mary Malefyt	*Illinois Violence Prevention Authority*
Daniel Martinez	*Illinois Psychiatric Society*
Beth Maschinot	*Mental Health Association in Illinois*
Samuel J. Meisels	*Erikson Institute*
David R. Michaeli	*Illinois Violence Prevention Authority*
Joann C. Moncado	*Illinois School Nurses Association*
Peter Nierman	*Illinois Department of Human Services*
Ginger Ostro	*Chicago Metropolis 2020*
Kay Pangle	*Illinois Association of Regional Superintendents of Schools*
Kathy Penak	*U.S. Department of Health and Human Services*
Ross Pesce	*J.S. Morton High School, District #201*
Ann Potter Francis	*Illinois Center for Violence Prevention*
Sharon Quintenz	*Illinois Department of Human Services*
C. Cybele Raver	*University of Chicago*
Peggy Richardson	*Illinois Federation of Families*
Thomas E. Ryan	*Sauk Village #168*
Linda Saterfield	*Illinois Department of Human Services*
Stephen Saunders	*Illinois Department of Human Services*
Suzanne Schmidtke	*National Alliance for the Mentally Ill*
Nancy Segall	*Illinois Association of Infant Mental Health*
Kathy Selcke	*Juvenile Justice Commission*
Susan Shea	*Illinois Education Association*
Anthony E. Sims	*Illinois State Board of Education*
Karen Sykes	*Chicago Public Schools*
Linda Taylor	*University of California at Los Angeles*
Toni Tollerud	*Illinois Counseling Association* / *Illinois School Counselors' Academy*
Roger Weissberg	*University of Illinois at Chicago (CASEL)*
Marlita White	*Chicago Department of Public Health / Office of Violence Prevention*
John Wilhelm	*Chicago Department of Public Health*
Paula Wolff	*Chicago Metropolis 2020*
Sharon Zahorodnyj	*Community Behavioral Health Care Association of Illinois*

BEST COPY AVAILABLE

In addition to Task Force Members, the following individuals participated on Task Force committees:

Kristin Allen	*Illinois Alliance of Boys & Girls Clubs*
Raquel Bassuk	*Casa De Los Ninos*
Nagamani Beligere	*University of Illinois*
Susan Blumenfield	*Metropolitan Family Services*
Tina Copeland	*University of Illinois at Chicago*
Aisha Cornelius	*Fight Crime: Invest in Kids*
Lina Cramer	*Illinois Family Partnership Network*
Ann Cutler	*University of Illinois at Chicago*
Lynnare Deutsch-Claudio	*Illinois Department of Children and Family Services*
Chelona Edgerly	*Cornerstone: Foundations for Family*
Helen Roberts Evans	*Child Care Center of Evanston*
Joane Evans	*SWCASA*
Kathy Fink	*Family Service*
Evan Freund	*HCI*
Linda Gilkerson	*Erikson Institute*
Phyllis Glink	*Harris Foundation*
Betsy Goulet	*National Children's Alliance*
Debbie Gross	*Rush University*
Marissa Happ	*Kane County Health Department*
Kay Henderson	*Illinois State Board of Education*
Angela Higgenbotham	*Chicago Public Schools*
Les Inch	*Children's Home and Aid Society*
James C. Jones	*ChildServ*
Barbara Kaplan	*Illinois State Board of Education*
Janet Katschke-Hansen	*Illinois Counseling Association*
Teresa Kelly	*Children's Foundation*
Katie Klehr	*Illinois Psychological Association*
Kathy Kloppenburg	*Carol Robertson Center for Learning*
Anthony Kopera	*Community Counseling Centers of Chicago*
Richard F. Kotz	*Mental Health Association in Illinois*
Tracey Kreipe	*Ounce of Prevention Fund*
Dana Kuhlemeyer	*Stephenson County Health Department*
Susan Laue	*Mental Health Association of the North Shore*
Lannie LeGear	*Community Counseling Centers of Chicago*
Elaine Leslie	*Easter Seals Children's Development Center*
Gregory Lewis	*Cook County Hospital*
Lynn Liston	*Rockford Memorial Hospital*
Barb Maier	*National Alliance for the Mentally Ill*
Amanda Marlow	*Adams County Health Department*
Maria Matticks	*Illinois Department of Human Services*
Lisa McGlothlin	*Child and Family Connections*
Mary Miller	*Illinois Department of Human Services*
Susan Miller	*DuPage County Health Department*
Mark Moses	*Ada S. McKinley Community Services, Inc*
Cheryl Mroz	*The Child Study Center*
Susan Munro	*Stean Family Foundation*
Evelyn Norton	*Illinois Department of Human Services*
Svndi Peck	*Transitions of Western Illinois*
Anne Pezzillo	*Children's Advocacy Clinic*
Viviana Ploper	*Community Counseling Centers of Chicago*
Cristine Pope	*Interfaith Leadership Project*
Ann Potter Francis	*Fight Crime Invest in Kids*
Susan Rakis	*Girl Scouts of America*
Leticia Ramirez	*El Valor*
Paul Riel	*Clinical Psychologist*
Sandra Rigsbee	*Frazier School Health Center*
John Roope	*Chaddock Child and Family Center*
Margie Schaps	*Health and Medicine Policy Research Group*
Nancy Shier	*Ounce of Prevention Fund*
Martha Schriver	*Mental Health Association of Greater Chicago*
Katie Silverman	*University of Illinois at Chicago*
Leo Smith	*Birth to Five PAC*
Ronald Stevens	*Administration for Children and Families, Region V*
Hellen Stewart Nava	*Filmore Center*
Marge Stillwell	*Illinois Head Start Association*
Martha Stouffer	*Dupage County Health Department*
Melissa Szymczak	*YWCA Child Care Resource and Referral*
John Tschoe	*Administration for Children and Families, Region V*
Mark Valentine	*Illinois Department of Human Services*
Eurnestine Brown Wells	*Ounce of Prevention Fund*
Dina Zarella	*Campaign for Better Health Care*
Peter Zimmerman	*Mather High School*

BEST COPY AVAILABLE

CONTENTS

Foreword	iv
Acknowledgements	vi
Executive Summary	vii
Introduction	2
A Vision for Children's Mental Health in Illinois	3
Children's Mental Health Facts	7
Barriers and Opportunities for a Comprehensive Children's Mental Health System	8
Task Force Recommendations	14
Appendix A: Public Systems, Services and Programs That Serve Illinois Children	26
Selected Children's Mental Health Resources	39
References	42

FOREWORD

In the spring of 2001, a small group of advocates and education leaders visited a high school in Illinois. The issues facing students were striking and disturbing - students were depressed, traumatized by exposure to violence in the home and community, and greatly in need of someone to talk to about their anxieties and concerns. The group decided to convene a workgroup to explore children's mental health. This workgroup produced a White Paper and recommended that the Illinois Violence Prevention Authority convene a Task Force on Children's Mental Health, which began its work in June of 2002.

It is with great pleasure that the Illinois Children's Mental Health Task Force presents its Final Report, *Children's Mental Health: An Urgent Priority for Illinois.* Over 100 people from various backgrounds and professions worked diligently to research the findings and formulate the recommendations contained in the Report. The Report represents a first major step in the long haul work of creating a mental health system that is truly responsive to the social and emotional development needs of children.

Research has clearly demonstrated that social and emotional well-being is essential for children's healthy development and critical to their ability to learn and succeed in life. Mental health promotion for children of all ages must be as high a priority for families and child serving systems as academic preparedness and physical health. Children are born with great promise, and we must do everything possible to help them develop socially and emotionally so they can meet the challenges of learning and living in today's complex society. Unfortunately, many children including very young children experience psychological trauma and mental health problems that, if untreated, negatively affect their brain, their behavior, and their academic and social success. Services must reach these young children and their families early to avoid more serious and costly problems. A full range of treatment services must also be available for those children who suffer from serious mental health disorders.

Sadly, we are failing our children in these very important areas. The children's mental health system in Illinois can barely be called a system. There is little or no emphasis on prevention or early intervention, and only a small percentage of Illinois children who need mental health treatment receive it. While many agencies and systems in Illinois, including child welfare, educational, human service and juvenile justice systems, attempt to address children's mental health, there is little coordination, and resources are not maximized, leaving children, families, schools and communities struggling to cope with children's mental health needs and problems.

The Children's Mental Health Task Force Report presents a cutting-edge approach to the continuum of mental health development, support and treatment that children need from birth to age eighteen. Illinois is one of a handful of states with the momentum and will of numerous child-serving groups and agencies to undertake such a comprehensive initiative-an initiative that has the potential to dramatically change the State's current mental health system. Implementation of the recommendations in the Report would give our State the resources and tools to begin creating a children's mental health system that strives to meet the needs of all Illinois children. We can make immediate and major strides toward this end if we join together to achieve the goals outlined in the Report.

We look forward to working with Illinois policy makers, community institutions and families to build our children's social and emotional strength so that they can become happy, achieving students and productive, caring citizens. We have enormous hope that Illinois will become a national leader in this effort.

Barbara Shaw
Chair, Illinois Children's Mental Health Task Force
Director, Illinois Violence Prevention Authority

Acknowledgements

This Illinois Children's Mental Health Task Force report is the result of the work and contributions from over 100 groups and individuals committed to and concerned about children's mental health in Illinois. The Task Force was convened by the Illinois Violence Prevention Authority (IVPA) in collaboration with other public and private agencies. Under the leadership of the Task Force Chair, Barbara Shaw, and the Executive Committee, the Task Force considered those issues most pertinent to reforming the children's mental health system, deliberated about key recommendations, and reached consensus on the recommendations contained in the Final Report. Members of the Task Force's three committees (Early Childhood, School-age, and Policy and Resource), whose membership extended beyond the Task Force, spent countless hours discussing system needs and recommendations for inclusion in the report, and provided important background information. Carolyn Cochran Kopel, Associate Secretary, Illinois Department of Human Services, conducted a survey of state agencies that provided the Task Force with critical information regarding existing state systems and services. The work of the Task Force was built on the *White Paper on Mental Health Services for Children and Youth in Illinois,* developed by the Children's Mental Health Work Group, as well as the work of the Social and Emotional Health Committee of the Birth to Five Project. Dave Michaeli, University of Chicago Metcalf Intern, provided important staff support to the Task Force. David Anger, IVPA staff member, also provided critical support and assistance. Blue Cross/Blue Shield of Illinois graciously provided the facilities for Task Force meetings.

The Illinois Violence Prevention Authority and the Irving B. Harris Foundation provided financial support for the work of the Task Force. Voices for Illinois Children and the Ounce of Prevention Fund offered invaluable assistance in securing financial support. The Office of the Attorney General donated the printing of the final Task Force report.

This report was written by Karen VanLandeghem, a consultant to the Task Force. Graphic design was generously donated by Creativille, Inc. (www.creativille.net); Steve Hartman, President.

Executive Summary

With Gubernatorial and Legislative leadership, Illinois can bring fundamental and timely reform to a system of children's mental health services that is highly fragmented, limited in scope and under-resourced. By building on existing programs and creating new ways of doing business, Illinois can create a comprehensive, coordinated children's mental health system of prevention, early intervention, and treatment for children ages 0-18 years. This system will engage families and caregivers, deliver services in natural settings, and integrate mental health services within and across early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, corrections, and other relevant systems.

Research clearly demonstrates that children's healthy social and emotional development is an essential underpinning to school readiness, academic success, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services and welfare dependency. Unfortunately, a significant number of Illinois children experience serious mental health problems and many of them do not receive the services they need.

Key Findings

- **Early prevention and intervention efforts can save significant state costs.** Untreated mental health problems in children have serious fiscal consequences for the state. Exposure to violence, depression, and other mental health problems affect children's ability to learn and increase their propensity for violence, alcohol and substance abuse, and other delinquent behaviors that are extremely costly to treat. Nearly 70% of those in the juvenile justice system have mental health problems. Many of these problems could have been prevented or ameliorated with appropriate intervention early in life.

- **A significant number of Illinois children experience serious mental health problems.** One in 10 children in Illinois suffers from a mental illness severe enough to cause some level of impairment; yet, in any given year only about 20% of these children receive mental health services. A recent study in Chicago found that nearly 50% of inner-city adolescents demonstrated signs and symptoms of depression. Another study revealed that 23% of Illinois adolescents and 34% of Chicago adolescents suffered signs of depression for two or more weeks in a row that kept them from doing usual activities. Nationally, over 20% of youth experience a diagnosable mental health problem.

- **Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts.** While many of the emotional and behavioral problems that children face can be prevented or minimized, the majority of children and youth with mental health needs do not receive preventive or early interventions- evidence-based interventions that are known to be effective.

- **Children's social and emotional development is an essential underpinning to school readiness and academic success.** According to national estimates, one-quarter to one-third of young children are perceived as not being ready to succeed in school. For a significant number of these children, concerns center on social and emotional issues. A recent Illinois survey found that 42% of childcare programs had to ask a family to withdraw a child because the staff were unable to manage the child's behavior. The social and emotional development of children must be addressed as a fundamental part of their development from early childhood through adolescence.

- **A comprehensive, coordinated children's mental health system can help maximize resources and minimize duplication of services.** Mental heath promotion and prevention programs in schools and early childhood programs are not an established part of these systems and are usually provided only if the school or program is able to capture special grant funds for these purposes. Screening, identification, and service systems for children are currently fragmented, under-resourced and inadequate to address the number of children and their families who need mental health support. A comprehensive, coordinated and collaborative system in Illinois needs to be developed to maximize resources and ensure that planned and focused efforts achieve the maximum results possible.

Key Principles

- A successful children's mental health system engages families and caregivers. Parents and caregivers have an enormous impact on the social and emotional well being of their children. Most understand the important role they play in their child's development, but many lack critical knowledge and information. To be effective, a children's mental health system must engage and partner with parents and caregivers at every point on the continuum of services from prevention and early intervention, to treatment.

- Prevention and early intervention efforts should start early, beginning prenatally and at birth, and continue throughout adolescence (i.e., children ages 0-18). Childhood, beginning at birth, is the time to promote optimal healthy development and prevent mental disorders and emotional/behavioral problems to help ensure success in school and in life. Programs and services should build on the strengths of children, youth and their families.

- All children and their families should have access to affordable, quality, family-centered, culturally competent interventions and services. Prevention, early intervention and treatment services should be tailored to reach children living in rural, suburban and urban areas, and must address language, income, and other possible barriers that can affect children's healthy development and access to services.

- Public and private resources must be maximized and coordinated, and should build on existing state and local systems and programs. A statewide, collaborative, multidisciplinary, community-based systems approach will ensure that Illinois children and youth receive a cost-effective continuum of prevention, early intervention, and treatment services.

- Children's mental health services should be delivered in natural settings if they are to successfully reach children, youth and their families. Providing services in natural settings, like homes, primary care environments, community programs, early childhood programs, schools, or school-linked programs, increases the likelihood of reaching and maintaining contact with children, youth and families who face many barriers to receiving those services in the community.

Building an effective children's mental health system calls for a unified, long-term strategy in which scarce funds are maximized, programs and services are integrated, and investments are made for the future. This Illinois Children's Mental Health (ICMH) Task Force report represents the collective knowledge, vision and endorsement of over 100 state agencies, child advocacy groups, health and mental health providers, educators and academicians committed to and concerned about children's mental health in Illinois. It is a blueprint for constructing a new system of children's mental health. Further work will be needed over the coming months and years to analyze existing systems, determine ways to best coordinate efforts, identify the respective roles of state and local agencies, maximize resources, and implement short and long-term activities.

Building an effective children's mental health system calls for a unified, long-term strategy in which scarce funds are maximized, programs and services are integrated, and investments are made for the future.

The ICMH Task Force has identified the following priority recommendations as critical to achieving immediate successes, generating additional funding sources, and advancing a comprehensive system of children's mental health.

Priority Recommendations:

I. Make children's mental health a priority in Illinois.

A. Develop a Children's Mental Health Plan containing short-term and long-term recommendations to provide comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth through age 18.

B. Create a Children's Mental Health Partnership that reports directly to the Governor to develop and monitor the implementation of the Children's Mental Health Plan as approved by the Governor.

C. Require, through legislation, that the Illinois State Board of Education develop and implement a plan, to be submitted to the Governor by December 31, 2004, to incorporate social and emotional standards as part of the Illinois Learning Standards for the purpose of enhancing and measuring children's school readiness and ability to achieve academic success.

D. Require that all Illinois school districts develop a policy for incorporating social and emotional development into the district's educational program and submit the policy to ISBE by August 31, 2004. The policy should address teaching and assessing social and emotional skills and protocols for responding to children with mental health problems that impact learning ability.

II. Maximize current investments and invest sufficient public and private resources over time.

A. Maximize the use of Medicaid/KidCare by streamlining enrollment, capitalizing on federal reimbursement opportunities and implementing key cost-saving financing strategies, with savings deposited into a Children's Mental Health Fund. This includes strategies to:

1. Claim Medicaid reimbursement for Individual Care Grants (ICG) for children via the inpatient psychiatric services for individuals under 21. This is allowable under the existing state Medicaid Plan and would capture additional Medicaid Federal Financial Participation (FFP) claims of approximately $12 million per fiscal year, plus up to the two previous fiscal years.

2. Require Screening Assessment and Support Services (SASS) prior to all admissions of children for psychiatric hospitalizations that are funded by Medicaid. Increase SASS capacity to conduct these screenings and use the savings, obtained by serving children in the community instead of psychiatric inpatient hospitalization, to fund children's mental health services.

B. Create a Children's Mental Health Fund in the State Treasury to expand prevention, early intervention, and treatment services and programs for all children.

C. Strengthen the financing of children's mental health services within the Office of Mental Health (OMH) by significantly increasing funding and coordination, and appropriating adequate and proportionate funding across the age span for children ages 0-18 years.

III. Build a qualified and adequately trained workforce with a sufficient number of professionals to serve children and their families.

A. Expand and strengthen the professional preparation and workforce of mental health professionals who have expertise in children's (ages 0-18) mental health needs.

B. Expand and strengthen the professional preparation of primary care providers (e.g., pediatricians, family physicians), educators, paraprofessionals and others that come in contact with children and their families in the social and emotional development of children.

C. Improve relevant certification requirements in key professions to ensure a qualified and adequately trained workforce.

IV. Develop a comprehensive, multicultural, and multi-faceted public awareness campaign to reduce the stigma of mental illness; educate families, the general public and other key audiences about the benefits of children's social and emotional development; and inform parents, providers and others about how to access services.

V. Create a quality-driven children's mental health system with shared accountability among key state agencies and programs that conducts ongoing needs assessments, uses outcome indicators and benchmarks to measure progress, and implements quality data tracking and reporting systems.

VI. Establish a Children's Mental Health Research and Resource Center(s) to collect and facilitate research on best practices and model programs, share information with Illinois policymakers, practitioners and the general public, develop training and educational materials, provide technical assistance, and other key activities.

VII. Provide funding for culturally competent and clinically relevant research, including longitudinal studies that: address evidence-based practices in children's mental health prevention, early intervention, and treatment; are translated into practice standards and policy implications for key groups; and are used to improve programs and services.

INTRODUCTION

Children's mental health[i] is as important to their overall health, well-being and academic success as physical health, yet little attention is usually placed on this issue until problems become severe. Even though prevention and early intervention efforts have been shown to improve child outcomes, Illinois' current mental health system remains largely oriented towards treating only those children with the most severe mental health needs. Bold reform of a highly fragmented and under-resourced system is needed to create a comprehensive and coordinated mental health system that meets the needs of children ages 0-18 years, and their families.

Research indicates that the critical foundations for learning, school success, health and general well-being are established well before a child enters kindergarten. When children's social and emotional development and mental health needs are not addressed early, there are numerous costs to the state, children and their families, and systems. Nationwide, the cost of treating mental health needs in children and adolescents is estimated at nearly $12 billion.[1]

Because of recent research and the burgeoning numbers of children experiencing mental health problems, the social and emotional well-being of children has become a top priority at the state and national levels. In 2000, the U.S. Surgeon General released the first-ever report on mental health, underscoring the importance of early preventive mental health services and programs. The President's New Freedom Commission on Mental Health was recently formed to identify strategies to improve mental health-related services so that children and adults with emotional disturbances can live, learn and participate fully in their communities.

The Illinois Children's Mental Health Task Force was convened in June 2002 by the Illinois Violence Prevention Authority, in collaboration with key government agencies, child advocacy groups, community organizations, educators, health and mental health providers, academicians and others. The Task Force's goal was two-fold: 1) Assess the status of Illinois' mental health system for children ages 0-18 years, and 2) Develop short and long-term recommendations for assuring that all Illinois children have access to coordinated and comprehensive mental health services and programs.

Children's Mental Health: An Urgent Priority for Illinois is the culmination of several months of Task Force and Committee work examining research and policy studies, identifying key goals and recommendations, and deliberating about the priority areas most needed in Illinois. This Task Force Report is a blueprint for constructing a new system of children's mental health services in Illinois. Further work will be needed over the coming months and years to analyze existing systems, determine ways to best coordinate efforts, identify the respective roles of state and local agencies, maximize resources, and implement short and long-term activities.

---

i For purposes of this Task Force report, the terms "social and emotional development" and "mental health" are used interchangeably to refer to the overall mental health of children (i.e., developmental, behavioral, social and emotional health).

A Vision for Children's Mental Health in Illinois

The Illinois Children's Mental Health Task Force envisions a comprehensive, coordinated children's mental health system comprised of prevention, early intervention, and treatment for children ages 0-18 years. Programs and services would be available and accessible to all Illinois children and their families - whether they are a new parent adjusting to the demands of parenthood, a toddler struggling to master basic developmental tasks, an adolescent who is experiencing feelings of depression, or a youth with some other mental health need.

A comprehensive and coordinated children's mental health system in Illinois would:

- Start early, beginning prenatally and at birth, and continue throughout adolescence, including efforts to support adolescents in making the transition to young adulthood.
- Engage families and caregivers in all aspects of promoting their child's optimal social and emotional development, and overall mental health.
- Educate families, children, providers and the general public about the importance of children's mental health.
- Provide quality services that are based on evidence-based research and are affordable, family-centered, culturally-competent, and developmentally appropriate.
- Deliver services in natural settings such as early childhood programs, homes, primary health care settings, and schools in order to successfully reach children and their families.
- Assure that all professionals who come in contact with children are adequately prepared and trained to promote, identify, refer and/or address children's mental health.
- Build on and integrate existing systems that serve children and their families.
- Maximize public and private resources and invest sufficient resources over time.

Prevention

Many mental health problems and disorders can be prevented or ameliorated through prevention and early identification. The Task Force envisions a children's mental health system where the promotion of children's optimal social and emotional development is embedded into every system, program and service that serves children and their families. These systems include early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, and corrections. Prevention efforts should help parents and caregivers establish early, strong parent-child relationships and attachments, and help youth navigate key developmental milestones and develop important life and social skills. They should also extend to adult-focused systems that come into contact with families and children, such as health care, law enforcement, the judicial system, homeless shelters, mental health and domestic violence programs.

The promotion of children's optimal social and emotional development should be embedded into every system, program and service that serves children and their families.

To support infants and young children, prevention efforts should be integrated into early childhood programs, educational systems, health care systems (e.g., well-child visits), and other key systems. Because most children ages 4-18 attend school or pre-school, schools play a central role in promoting social and emotional development. Children's social and emotional development should be viewed as a core part of a school's mission, critical to the development of the whole child, and necessary for school readiness and school success. By integrating an emphasis on social-emotional learning in schools, students are better able to resolve interpersonal problems and prevent antisocial behavior, as well as to achieve positive academic outcomes.[2]

Early Intervention

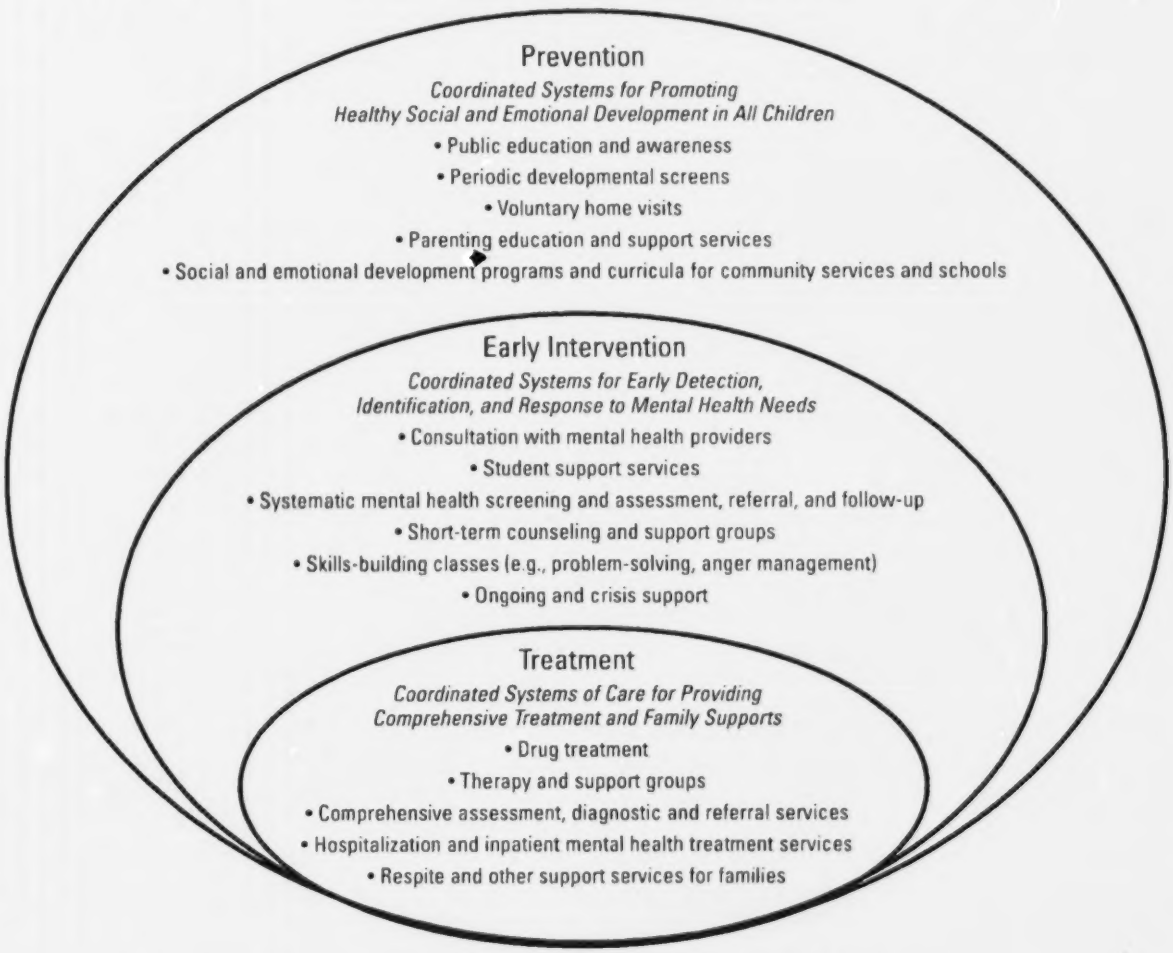
Systemic and periodic early identification efforts can help assure that children who have mental health needs are identified early, and provided with or referred to appropriate programs and services. Systems and programs that serve children (e.g., early childhood programs, schools, health care) should be equipped to identify the early warning signs of problems in social and emotional development. This includes addressing problems that are not serious enough to result in a diagnosis but nonetheless require some type of intervention such as counseling, support groups, or skills-building classes. Child-serving systems should have the capacity to provide early intervention through: consultation with mental health providers; services provided directly in child-centered settings (e.g., early childhood programs, schools and pre-schools) by psychologists, counselors, social workers, and other mental health professionals; or referrals to community agencies and providers. In addition, children who are being served by systems such as the Early Intervention Services System, Special Education, child welfare and juvenile justice, should be assessed for mental health needs and where indicated, receive timely and appropriate follow-up.

BEST COPY AVAILABLE

Treatment

Children who have mental health problems and disorders, and their families should have access to a comprehensive system of care of mental health services and supports. Mental health services should be based on the needs of the child and their family, community-based and collaborative, culturally sensitive and responsive to the populations being served, and provided in natural settings when possible. They should address issues such as disruptions and impairments between parents and children, or circumstances in which a child's social and emotional development has deviated significantly from typical behavior. Families should not be forced to place their child in residential care when alternative approaches that keep children and families intact are or could be available. Moreover, children should not be placed in juvenile justice or other such systems because mental health interventions, which could help prevent juvenile detention in the first place, are not available.

Framework for a Coordinated Mental Health System* in Illinois for Children Ages 0-18


Prevention
Coordinated Systems for Promoting Healthy Social and Emotional Development in All Children
• Public education and awareness
• Periodic developmental screens
• Voluntary home visits
• Parenting education and support services
• Social and emotional development programs and curricula for community services and schools
Early Intervention
Coordinated Systems for Early Detection, Identification, and Response to Mental Health Needs
• Consultation with mental health providers
• Student support services
• Systematic mental health screening and assessment, referral, and follow-up
• Short-term counseling and support groups
• Skills-building classes (e.g., problem-solving, anger management)
• Ongoing and crisis support
Treatment
Coordinated Systems of Care for Providing Comprehensive Treatment and Family Supports
• Drug treatment
• Therapy and support groups
• Comprehensive assessment, diagnostic and referral services
• Hospitalization and inpatient mental health treatment services
• Respite and other support services for families

*These systems include early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, corrections, and other relevant systems.

Adapted from: Minnesota Children's Mental Health Task Force, *Minnesota Framework for a Coordinated System to Promote Mental Health in Minnesota;* Center for Mental Health in Schools, *Interconnected Systems for Meeting the Needs of All Youngsters.*

BEST COPY AVAILABLE

Early Investments Can Prevent More Costly Interventions

Childhood is the best time to promote optimal social and emotional development and to prevent mental disorders. Research shows that the precursors for many adult mental disorders can be found in childhood.[3] Prevention programs and early intervention efforts targeted to women, infants, and children, particularly those who are low-income, have been shown to be beneficial and cost-effective.[4] These efforts can improve school readiness, health status, and academic achievement, and reduce the need for grade retention, special education services and welfare dependence.[5]

Decades of research reveal that human development is a dynamic and interactive process between genetics and experience that occurs rapidly from birth to age five but is also life-long. Optimal mental health in childhood and adolescence is marked by the achievement of key milestones - those critical points in a child and adolescent's life where they attain expected developmental, cognitive, social, and emotional markers - and by secure attachments, satisfying social relationships, and effective coping skills.[6] Early environments and experiences, nurturing relationships, human interaction, and culture are among the factors that play a critical role in a child's development.[7]

Many Children Experience Mental Health Problems

Children from all socioeconomic and ethnic backgrounds can have mental health needs ranging from problems that are not at the diagnosable level to those which can cause severe impairments. At least one in 10 - or as many as 6 million children - suffers from a mental illness that severely disrupts daily functioning at home, in school or in the community.[8] However, in any given year less than 20 percent of these children receive mental health services.[9] Both biological factors and negative psychosocial experiences during childhood can influence mental disorders in children and adolescents.[10]

At least one in 10 - or as many as 6 million children - suffers from a mental illness that severely disrupts daily functioning at home, in school or in the community.

While all children can experience mental health problems, some are more vulnerable or likely to have mental health needs than others. Risk factors for experiencing problems in social and emotional development, or developing a mental disorder include[11]:

- prenatal damage from exposure to alcohol, illegal drugs, and tobacco;
- low birth weight;
- poverty;
- abuse and neglect; and
- exposure to traumatic events or violence.

Youth who are homeless or have run away from home; who are in foster care or group homes; who are gay, lesbian, bisexual or transgender; and who are incarcerated may be more prone to having mental health needs. Recent research reveals that the prevalence of mental health problems in incarcerated youth is far more significant than earlier estimates. Among adolescents in juvenile detention, nearly two thirds of boys and three quarters of girls have at least one psychiatric disorder.[12]

Children's Mental Health Facts:

- Nationally, over 20 percent of youth experience a diagnosable mental health problem.
- One-quarter to one-third of young children are perceived as not being ready to succeed in school, with many affected by social and emotional issues.
- 42% of Illinois childcare programs participating in a recent survey reported having to ask a family to withdraw a child because staff were unable to manage the child's behavior.
- A survey of child care providers in 10 Chicago centers found 32 percent of children (including toddlers) had behavioral problems.
- Suicide is the third leading cause of death for adolescents and young adults.
- Nearly one-quarter of Illinois adolescents and one-third of Chicago adolescents reported signs of depression for two or more weeks in a row that kept them from doing usual activities.
- Students ages 12 through 18 were victims of approximately 186,000 violent crimes in schools; nearly 500,000 witnessed violent crimes away from school.

Sources: U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, 1999; J Knitzer, *Using Mental Health Strategies to Move the Early Childhood Agenda and Promote School Readiness*, and C Raver and J Knitzer, *Promoting the Emotional Well Being of Children and Families Policy Paper #3*. New York: New York, National Center for Children in Poverty; L Gilkerson and A Cutler, *Illinois Infant Mental Health Survey: Findings and Recommendations*. Chicago, IL: Erikson Institute and University of Illinois, 2001; NCHS National Vital Statistics System for numbers of deaths, U.S. Bureau of Census population estimates; Centers for Disease Control and Prevention, Youth Risk Behavior Survey, 2001; and U.S. General Accounting Office, *Child Trauma and Mental Health Services Report to Congress*. U.S. Government Printing Office.

"Lisa, a 9 year old girl, called 911 one night to stop her stepfather from beating her mother and siblings. Terrorized, Lisa alternatively screamed for help while expressing concerns for her siblings. She told police that her stepfather often gets drunk and is violent towards her mother and newborn baby sister. The call ended abruptly when Lisa screamed "Oh my God" and hung up the phone. The next day in school, Lisa was withdrawn and distracted, and spent the afternoon in the nurse's office complaining of a stomachache."

Families Play a Critical Role and Need Ongoing Services and Supports

Children and their families need ongoing services and supports throughout childhood and adolescence in order to assure success in school and in life. Families and caregivers play a central role in promoting their child's social and emotional development. They also are critical partners in developing child treatment plans, and informing system-level policy decisions. While most families understand the important role they play in their child's development, many admit that they lack critical knowledge and information about how they can best support their child in this area.[13]

For families who have children with mental health needs, comprehensive services and supports can be even more critical. Mental health disorders in children can take a significant toll on families. Job loss, strained marriages and divorce, isolation, and negative affects on siblings are just some of challenges facing these families. When there are barriers to obtaining needed services, the effects can be tremendous. In a recent national survey of parents of children with mental health disorders, 23 percent reported being told that they would have to relinquish custody of their child to get needed services; 20 percent of these families said that they did so to get care.[14]

Children are dependent on their families and caregivers for their sustenance, nurture, stimulation, and guidance. When a parent or caregiver has a mental health need, this can effect the mental health of their children. For instance, research shows that infants and toddlers of depressed parents are less attentive and fussier, 6-8 times more likely to be diagnosed with a major depressive disorder, and 5 times more likely to develop conduct disorders.[15]

"Aliza is nearly 4 years old. Her mother, a single parent who works full-time, is having problems managing Aliza's behavior. Aliza constantly runs out of her child care classroom, frequently hits other children, and does not enjoy many of her activities. She has been kicked out of two child care centers. The director of the center that she currently attends informed her mother that other parents are complaining and the staff feel they can no longer keep Aliza in their care. Aliza's mother is distraught and is afraid she will lose her job."

Numerous Barriers Can Prevent Children and Their Families from Obtaining Needed Services

The current Illinois mental health system is like that of most other states - mental health services primarily address the needs of adults. In Illinois, while mental health services are available for children over age 3, most services are focused on the needs of children with severe mental health problems and disorders, and do not reach very young children. The system of care for children with severe mental health problems is grossly under funded[16] resulting in a lack of capacity to serve the children and families most in need. Few resources are available to adequately promote children's mental health and implement needed early intervention efforts. Where prevention and early intervention programs and services are offered, many are not integrated with other related efforts.

Lack of coordination and integration can mean that families often have to spend extra time navigating multiple programs and services, providers are unaware of community resources, and systems may risk duplicating efforts. When systems are inadequate to meet the needs of children, families can face tremendous obstacles in obtaining needed services for their children. In a national survey of parents, 36 percent reported that their children were placed in the juvenile justice system because needed mental health services were not available.[17]

Most systems are currently under-resourced and ill-equipped to proactively address children's mental health needs.

Low-income and minority children experience greater barriers to care than other children. Disparities in access to health care services, including mental health services, are evident in low-income, and Hispanic and African-American children.[18] Also, minorities in treatment often receive poorer quality mental health care.[19] Barriers that all children can experience include:

- stigma,
- cost of services,
- insufficient mental health coverage in private insurance benefits packages,
- inadequately trained providers, and
- a lack of bilingual and bicultural providers.

Most systems are currently under-resourced and ill-equipped to proactively address children's mental health needs. For example, few, if any, Illinois schools implement a systematic method of screening for mental health needs. Those that do conduct screenings are often unable to meet the treatment needs of children identified as having mental health problems. Support staff such as school counselors, social workers and psychologists often have limited time to address those children who have or are at risk of developing an emotional disorder.[20] This phenomenon is seen in many Illinois systems. Lack of resources, time, training and providers prevent many programs from implementing more comprehensive mental health interventions.

"I am desperate for help with a child who is making my life and that of the other children in my care quite stressful. Johnny is thirty-three months old and quite a bit larger than the other children his age, yet his speech is limited and difficult to understand. Johnny lashes out at others. Just yesterday, he bit two children, kicked me, slapped my co-worker across the face, and spit his juice out at snack time. He throws uncontrollable tantrums when asked to do routine activities such as cleaning up the play area or laying down for a nap. The other children fear him; some of them cry when he sits next to them or tries to play; others just prefer to hand over their toys and walk away. Our child care center has a three-to-one ratio of teachers to children in the classroom, so it is not as though he lacks attention. One parent has already removed her child from our program because of him and another parent is on the verge of doing the same. We really want to help Johnny and avoid asking his family to remove him from our program, but we are running out of ideas."

What Parents and Caregivers Think

Parents and caregivers rely on mental health and health care providers, educators, and other professionals for needed information, expertise and guidance. Yet, national surveys indicate that many of the professionals who have regular contact with children are not always adequately prepared to address children's mental health needs.

- In a national survey of parents with young children, parents were least satisfied with the extent to which their child's regular doctor helped them understand their child's development.
- Only 34 percent of parents in a recent survey reported that their primary care physician routinely evaluated mental, emotional and behavioral issues and nearly half of parents stated that their child's primary care physician did not recognize a serious mental illness.
- Only 7 percent of parents indicated that school professionals were trained and prepared to deal with serious mental illness in youth.
- Only 16 percent of parents believed that their school system quickly evaluated their children and placed them in an appropriate special education class.
- Nearly three-quarters of parents indicate that their child must fail before additional services are placed in schools.

Sources: Commonwealth Institute for Child and Family Studies and the Department of Psychiatry Virginia Commonwealth University. *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness: Results of a National Survey of Parents and Other Caregivers.* Arlington, VA: The National Alliance for the Mentally Ill, 1999; and Young KT, Davis K, and Schoen C. *The Commonwealth Fund Survey of Parents with Young Children.* New York: The Commonwealth Fund, 1996.

Because of these and other barriers, interventions need to be tailored to reach children living in rural, suburban and urban areas, and address language, income, and other obstacles. Providing services in natural settings, such as homes, health care systems, community programs, early childhood programs, and schools or school-linked programs can increase the likelihood of reaching and maintaining contact with children.

Mental health and health providers, educators, social workers and other professionals play a critical role in addressing children's mental health needs. Because of their regular contact with children, these professionals need to have the knowledge and skills to effectively serve children and youth, and intervene appropriately when risk factors or problems surface. This requires appropriate training and qualifications, and opportunities to continually learn new, evidence-based, culturally-competent practices.

Existing Systems and Services Need to be Integrated and Comprehensive

Children, adolescents and their families come in contact with multiple systems that are critical access points for prevention, early intervention and treatment efforts. These systems include early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, and corrections. Each has an unprecedented opportunity to promote children's social and emotional development, detect problems early, and provide the necessary services or referrals to assure that mental health needs are addressed. Brief overviews of the Illinois systems and services that currently address the health, education and social service needs of children and their families are in appendix A.

At least seven state entities in Illinois have some type of responsibility for addressing the social and emotional development of children, but efforts are not integrated.

At least seven state entities (i.e., state agencies, divisions and departmental units) in Illinois have some type of responsibility for addressing the social and emotional development of children. However, the degree to which these entities address children's mental health varies and there is no overall vehicle for coordinating inter- and intra-agency efforts. A recent survey of these agencies and divisions revealed many gaps and barriers in the current system. They include:

- Fragmentation of the service delivery system and little continuity of care;
- A lack of clear guidelines for determining who serves children with mental health problems;
- Geographic pockets in the state where access to mental health services for children is limited;
- Little ability to assess overall system needs and determine whether services are meeting the needs of children and their families;
- An emerging population of youth in corrections and detention facilities who are in dire need of mental health services; and
- Inadequate private coverage for mental health services as compared to services offered in the public sector.

A statewide, collaborative, community-based systems approach to children's mental health could help assure that services were integrated and cost-effective, and minimize duplication of efforts. A "systems of care" approach can help address fragmentation of children's services by examining how services can be local, comprehensive, and meaningful to children and their families. Key systems are in place within the existing mental health system, including community mental health centers, State 708 Mental Health Boards, Local Area Networks (LANs), and the Screening Assessment and Support Services (SASS) that are important building blocks to a more comprehensive system of services for children. These systems need to be expanded and coordinated with other community-based systems and services in order to adequately address the mental health needs of children and their families. These systems can also make contributions to strengthen prevention and early intervention components of a comprehensive children's mental health system.

"Mill Street Elementary School (Naperville) implemented a research-based social and emotional learning (SEL) program in the fall of 1995. The school is very pleased with the program and overall improvements in student behavior. The principal notes, "Students have and are continuing to learn how to identify interpersonal problems, generate positive ways to solve problems, and choose an appropriate solution that will lead to desired results. Students are developing responsibility and ownership for their behaviors." The number of bus discipline referrals – one indicator of improved behavior – has notably decreased since the program was implemented. In addition, over the past three years the Assistant Principal and Principal have had to intervene with students no more than 12 times per year, which also represents a significant improvement in the behavior of the school's 800 students."

Opportunities for Accessing Children and Their Families

- Over 960,000 Illinois children were enrolled in Medicaid and KidCare in 2002.
- Approximately 40 percent of all babies born in Illinois are served by the WIC program.
- 133,400 three and four-year-old children are currently being served in state-supported early childhood programs; this represents 36 percent of the total population for this age group.
- Over 23,000 children were in foster/substitute care in 2002.
- Over 2 million children (i.e., 2,066,775) were enrolled in Illinois public schools, pre-K through 12th grade, during the 2001-02 school year.

Sources: Governor's Task Force on Universal Access to Preschool (2002), *Ready, Set, Grow; Illinois Kids Count 2003: The Window of Opportunity.* Chicago, IL: Voices for Illinois Children, 2003; Illinois Department of Children and Families web site accessed at http://www.state.il.us/dcfs/fc_foster.shtml ; and Illinois State Board of Education. Illinois Educational Statistics, School Enrollment accessed at http://www.isbe.state.il.us/research/brochure02.htm

Maximized Public and Private Resources Can Minimize Duplication and Save Costs

Numerous federal programs provide Illinois with funds that are either directly targeted to children's mental health or could be used to support an array of services in some capacity. Many of these federal resources offer considerable flexibility in the use of funds and program design, within federal parameters. Efforts that maximize and coordinate federal program funds, state general revenue funds (GRF), and local and private funds can result in better ways of using scarce resources and create new investments for children's mental health.

Further analysis is needed in order to examine how best to maximize and "braid" key federal and state program funds for children's mental health. Funding sources that should be examined include: Medicaid and SCHIP, the Social Services Block Grant, Temporary Assistance for Needy Families (TANF), the Child Care and Development Fund, the Title V Maternal and Child Health Services Block Grant, Parts B (i.e., Special Education) and C (i.e., Early Intervention) of the Individuals with Disabilities Education Act (IDEA), Juvenile Justice, and state funding sources. A thorough examination of federal and state funding sources accompanied by a targeted funding plan could, at the minimum, help minimize duplication of services.

Preliminary analyses reveal that Illinois could be using Medicaid more fully - by capturing more federal dollars, implementing cost-saving measures, and enhancing service delivery components within the current state program. Because Medicaid is one of the largest funding sources for children's health and mental health services[21], it is an important program to examine. Furthermore, if current proposed federal changes to Medicaid occur, they could result in significant modifications to the program at the federal and state levels.

Other service delivery enhancements in Medicaid are needed to help improve access to mental health services for children and their families. These include improving reimbursement of children's mental health prevention, early intervention, and treatment. Currently, the state's Office of Mental Health (OMH) certifies mental health agencies to bill Medicaid for services under Illinois Administrative Code (i.e., Title 59, Code 132; Medicaid Community Mental Health Services Program). Hospitals, schools, and private physicians bill the Department of Public Aid directly for clients enrolled in Medicaid. Private providers (i.e., social workers and psychologists) and agencies that are not hospital-based or certified by OMH cannot bill Medicaid for mental health services. Expanding Medicaid reimbursement to qualified professionals, including licensed clinical social workers, psychologists, and professional counselors, could help ensure that more services are available for children and their families.

Private Support of Children's Mental Health Services Needs to be Enhanced

Public policy regarding the delivery and financing of children's mental health services needs to consider both public and private domains. This means mobilizing private dollars through innovative public-private partnerships. It also entails ensuring that children's mental health services are adequately covered under private insurance plans.

Parity requires insurers to provide the same level of benefits for mental illness and other mental health problems as for physical care. Currently, 46 states have enacted law addressing mental health coverage; however, these laws vary in their scope.[23] Illinois recently enacted Public Act 92-185 to address the parity (i.e., equality of coverage) of mental illnesses with physical illnesses in health insurance coverage. However, the law, which went into effect on January 1, 2002, does not apply to individual health plans, Health Maintenance Organizations or self-insured health plans. Moreover, it covers only nine serious mental illnesses (e.g., schizophrenia; bipolar disorders; depression in childhood and adolescence and panic disorder), leaving treatment of a number of childhood emotional disorders at risk of limited or no coverage.

"Daniel, a third grader, could not stay focused during class. His parents were sure it was because he was gifted and bored, while his teachers tried everything to encourage his learning. Daniel often played in a fantasy with made up people rather than with other children. When he became aggressive and began to fall behind academically, his parents took him to a psychiatrist but their health insurance only covered 10 visits. Because the medication prescribed to Daniel did not adequately address his mental health problems so that he could remain in a regular school, he was placed in a therapeutic day school."

Bold Reform is Needed

The following recommendations are a blueprint for renovating the existing system of services and programs and constructing a comprehensive system of prevention, early intervention and treatment in Illinois.

---

ii Federal Medicaid law requires only one documentation requirement: individuals seeking coverage who are not citizens or nationals of the United States must provide proof of immigration registration from the Immigration and Naturalization Service.

Illinois Children's Mental Health Task Force Recommendations

I. Make Children's Mental Health a Priority: Infrastructure

A. Assign a senior-level staff person from the Governor's office to oversee and coordinate further work and implementation of the Children's Mental Health Task Force recommendations.

B. Develop a Children's Mental Health Plan containing short-term and long-term recommendations to provide comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth through age 18.

C. Create a Children's Mental Health Partnership that reports directly to the Governor, with a designated Chair and assigned staffing, to develop and monitor the implementation of the Children's Mental Health Plan as approved by the Governor. The Council should:

1. Be comprised of the Director or designee(s) of DHS, ISBE, DCFS, IDPA, IDPH, IVPA and DOC; the Attorney General or designee(s); up to 25 representatives of statewide mental health, children and family advocacy, early childhood, education, health, substance abuse, violence prevention, and juvenile justice organizations or associations to be appointed by the Governor; and two members of each caucus of the House and Senate appointed by the Speaker of the House and the President of the Senate.

2. Build on and use the Illinois Children's Mental Health Task Force Final Report recommendations in developing the statewide strategic plan with recommendations for promoting and strengthening prevention, early intervention, and treatment.

3. Make policy and planning recommendations to the Governor regarding the state budget for prevention, early intervention and treatment across all state agencies. In order to ensure a focus on prevention and mental health promotion, the recommendations should include a prevention budget across agency and departmental lines.

4. Establish state and local mechanisms for integrating federal, state, and local funding sources for children's mental health.

5. Develop and oversee mechanisms for the integration of state, regional and local children's mental health programs and services.

6. Examine mechanisms for coordinating children's mental health services and programs in communities, with the goal of building on existing local systems, maximizing resources, and coordinating planning, policy implementation, and service delivery.

7. Create guidelines that determine who serves populations of children to avoid disputes and unnecessary delays in serving children (e.g., MI, DD, SA, DOC, DCFS, ISBE, and Youth Services).

8. Identify evidence-based programs to be used as models for developing and strengthening prevention, early intervention and treatment programs and services.

9. Provide guidance to the development of social and emotional learning standards for inclusion in the Illinois Learning Standards.

10. Work with the senior-level staff person from the Governor's office to implement the Children's Mental Health Task Force recommendations.

11. Make annual reports to the Governor, Legislature and other groups regarding progress towards achieving strategic plan recommendations.

D. Create children's mental health roundtables within each of the following agencies - DHS, ISBE, and DCFS - to ensure that children's mental health, and social and emotional development is integral to the mission, policy and programs of the agencies, and to coordinate existing resources and intervention strategies.

E. Incorporate children's social and emotional development as an essential element of the education and educational support system to address children's academic readiness and success. This should include:

1. Require, through legislation, that the Illinois State Board of Education develop and implement a plan, to be submitted to the Governor by December 31, 2004, to incorporate social and emotional standards as part of the Illinois Learning Standards for the purpose of enhancing and measuring children's school readiness and ability to achieve academic success.

2. Develop guidance for schools and school districts regarding schools' role in prevention, early intervention and treatment. Guidance should include:

a. Information about redefining administrative roles and functions in schools and school districts to ensure that there is dedicated administrative leadership able to facilitate and support systemic change.

b. Information about reframing the roles and functions of student support staff and community agency staff to focus on children's mental health.

3. Link school-based prevention, early intervention and treatment services to current state school goals (i.e., No Child Left Behind Act of 2002) in order to improve classroom behavior, student achievement, and school success.

4. Require that all Illinois school districts develop a policy for incorporating social and emotional development into the district's educational program and submit the policy to ISBE by August 31, 2004. The policy should address teaching and assessing social and emotional skills and protocols for responding to children with mental health problems that impact learning ability.

5. Monitor school systems' collecting and reporting of information about student progress on social and emotional development and the social climate of a school.

F. Use and build on the multiple intervention points where children, youth and families can be reached (e.g., WIC, child care, juvenile justice, schools, courts, foster care, social service system) to promote, intervene and refer for children's mental health services.

II. Develop and Strengthen Prevention, Early Intervention and Treatment Policies, Programs and Services for All Children

A. Prevention

All Children

1. Ensure that all children enrolled in Medicaid receive periodic developmental screens, including the social and emotional development areas, as mandated under the Early and Periodic Screening Diagnostic Treatment (EPSDT) program.

2. Develop and strengthen parent education and support services for all parents, especially new and at-risk parents.

3. Develop appropriate support services and linkages between systems during key life transitions for children (e.g., early childhood to school-age, high school to adulthood).

Young Children Beginning at Birth

1. Develop and implement services in or linked to healthcare settings to support and educate new parents regarding the psychological adjustment to parenthood and ways to promote a child's healthy social and emotional development.

2. Screen all pregnant women for depression prior to delivery and periodically in the six months following the birth of a child.

    a. Explore mechanisms for the public and private insurance reimbursement of such screenings conducted by health care professionals.

3. Review developmental screening practices across early childhood programs and health care services, and provide consultation and training to individuals conducting screenings to ensure appropriate and culturally relevant assessment of young children's social and emotional development with the use of standardized tools.

4. Disseminate information and referral protocols for the Special Education and Early Intervention systems, and community behavioral health care services to ensure that children are referred to the appropriate system, when indicated, and referring providers receive necessary feedback.

5. Provide at least two voluntary home visits by a registered nurse to all Illinois families following the birth of a child to assess the physical, social and emotional health of the new family, and link them to appropriate follow-up services as needed to prevent the emergence of developmental, behavioral and psychosocial problems.

School-Age Children

1. Establish state and community efforts to ensure that school districts and schools incorporate the social and emotional development of children as an integral component to the mission of schools, and view it as critical to the development of the whole child, and necessary to academic readiness and school success.

2. Work with the local education system and other relevant entities to ensure that:

   a. School districts and schools:

      i. Implement policies, and age- and culturally-appropriate programs and curricula that support children's social and emotional competencies, promote optimal mental health, and prevent risky behaviors, in all schools.

      ii. Incorporate mental health education in all school health curricula.

      iii. Provide parents and families with learning opportunities related to the importance of their children's optimal social and emotional development.

      iv. Train all school personnel, including administrative, academic, pupil support, and ancillary staff, in age-appropriate social and emotional competencies and how to promote them.

      v. Implement systems in schools (e.g., report cards) for providing feedback to parents and caregivers regarding children's social and emotional development.

      vi. Assure that all children have access to out-of-school programs that demonstrate best practice, promote children's healthy social and emotional development, and provide academic enrichment.

      vii. Establish partnerships with diverse community agencies, including non-traditional organizations, in order to assure a comprehensive, coordinated approach to addressing children's mental health, and social and emotional development.

   b. Community mental health and social service agencies:

      i. Incorporate the promotion of children's social and emotional development in existing programs and services.

      ii. Build organizational and staff capacity, including staff training and professional development, to address the social and emotional development, and mental health needs of school-age children.

      iii. Establish partnerships with early childhood programs, school districts and schools in order to ensure a comprehensive, culturally sensitive, coordinated approach to addressing children's mental health, and social and emotional development.

      iv. Establish formal agreements with key school and community stakeholders (e.g., child welfare, prevention, community behavioral health, public health, domestic violence, juvenile justice, law enforcement).

B. Early Intervention

All Children:

1. Identify and incorporate research-based curricula, culturally and linguistically appropriate materials, and approaches that enhance children's social and emotional development into programs serving all children.

2. Build the capacity of child-serving systems and agencies (e.g., health care systems, schools, special education, community mental health systems) to provide early intervention services with funding mechanisms that do not require a diagnosis for services for low and moderate-risk groups.

3. Develop interagency provider agreements between adult-centered programs and programs for children 0-18 years, as appropriate, to ensure the availability of early intervention services for the entire family.

    a. Train providers in adult systems to infuse parent education and support into the work with adults, when appropriate, and provide funding for pilot models.

4. Develop and fully implement policies and programs to ensure that all children coming through key public systems are assessed for mental health concerns and receive follow-up services as appropriate. This includes full implementation of DCFS' Integrated Assessment Services Model and assessments of children in the juvenile justice system.

5. Develop policies and support services within substance abuse treatment centers, domestic violence, homeless shelters and other appropriate programs so that children can remain with their primary caregiver, when appropriate.

6. Increase the availability and quality of mental health services for families involved with the child welfare system, and infants and children exposed to violence.

7. Increase the availability and quality of respite services to families with a child who has a developmental delay or disability, and those involved in the child welfare system.

8. Ensure that parents have access to ongoing, culturally relevant parent education and parent-to-parent support groups through the Special Education and the Early Intervention Programs as well as family and adult-focused programs.

9. Develop "rapid response crisis" models so that schools, early childhood programs, and community-based agencies are equipped to respond to local and/or national crises (e.g., school shootings, natural disasters, terrorism).

Young Children Beginning at Birth:

1. Provide mental health consultation and training to early childhood programs and providers to build their capacity to identify and intervene with infants and children whose behavior has begun to deviate from the normal range of development.

2. Require that all children who are referred to the Special Education or Early Intervention system be screened for social and emotional concerns and receive appropriate follow-up services as part of the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).

3. Evaluate the *Early Intervention Social and Emotional Pilot Project* and utilize outcomes to refine and implement effective practices across the entire Early Intervention system for identifying and serving children with a social and emotional developmental delay or psychosocial condition.

School-age Children:

1. Develop a system and protocols for periodic and universal screening, assessment and care management in school-age children as a preventive strategy and a basis for early intervention for psychosocial and related behavior problems.

2. Utilize and strengthen existing delivery mechanisms to meet student and family needs, including student support services (e.g., social workers, psychologists, counselors, nurses, and speech and language therapists), school-based behavioral health services, and school-community linked behavioral health services.

3. Establish systems that identify needs and provide early intervention services for certain high-risk groups (e.g., homeless and runaway youth; lesbian, gay and transgender youth).

4. Build the capacity of schools, out-of-school programs and other systems and agencies to provide early intervention services or make the necessary referrals.

C. Treatment

All Children

1. Build the capacity of early childhood programs, schools, community mental health centers, and other community services to treat or refer for the mental health needs of all children and their families through a coordinated system that provides access to all available, evidence-based treatments in the least restrictive environment.

    a. Work with health care, juvenile justice, child welfare, and other key systems to assure proper assessment, intervention and treatment.

2. Assure that children of all ages have access to an array of comprehensive assessment and treatment planning services and supports that are culturally and linguistically appropriate. Services should include but not be limited to:

    a. Comprehensive assessment and diagnostic services,

    b. Individual, parent-child, family and group psychotherapy,

    c. Mental health intervention services provided in children's natural environments (e.g., the home, child care center, school),

    d. Therapeutic nursery/day treatment (for young children),

    e. Therapeutic interventions for children who have been abused or neglected, exposed to substance abuse in the home environment, witnessed violence, or who are at risk of developing serious mental health issues based on prior assessment and family history,

    f. Mental health consultation, with access to bilingual and bicultural professionals, to a program, provider and/or parent to strengthen and complement treatment services,

    g. Hospitalization and inpatient mental health treatment services, and

    h. Medication for specific diagnosed conditions.

3. Strengthen transitional support programs and linkages for specific populations who are most at-risk and need access to targeted mental health services (e.g., DCFS wards who age-out of the system, adolescents moving out of correctional facilities).

4. Evaluate the utilization of short and long-term residential services in order to: determine the adequacy, effectiveness and efficiency of services, identify needed transitional support services following discharge; and determine if there are appropriate alternative community-based services to meet the needs of children requiring this level of care.

Young Children Beginning at Birth

1. Ensure that new mothers who are diagnosed with perinatal depression receive timely and appropriate treatment and follow-up.

2. Improve and expand the eligibility criteria for Early Intervention and Special Education services for children with social and emotional delays and psychosocial diagnoses and increase the capacity of these systems to treat children with emotional and behavioral problems.

School-age Children

1. Change the state mental health code to increase to twelve the number of times adolescents age 12-18 years can receive mental health services without parental consent.

2. Increase children's access to school-based and school-linked treatment services and supports by building linkages with community organizations and agencies, and through use of new technologies such as telepsychiatry (i.e., via use of long-distance video technology).

3. Increase the number of school-based health centers equipped to provide mental health services.

III. Maximize Current Investments and Invest Sufficient Fiscal Resources Over Time

A. Maximize the use of key federal and state program funds for children's mental health and integrate multiple federal and state funding streams.

B. Create a Children's Mental Health Fund in the State Treasury from which funds can be appropriated to expand prevention, early intervention, and treatment programs and services available to children ages 0 - 18 years.

C. Strengthen the financing of children's mental health services within the Office of Mental Health (OMH).

1. Modify the existing OMH administrative policy to explicitly include mental health services for children ages birth to three years.

2. Appropriate adequate and proportionate funding across the age span for children ages 0-18 years, in the OMH budget.

3. Significantly increase funding and coordinate financing of children's mental health services.

D. Significantly increase funding and coordinate the financing of children's mental health services and programs across all appropriate state agencies, units of DHS, and ISBE.

E. Establish state funding sources and mechanisms, including incentive-based funding structures and community-based pilot projects, to promote best practices in prevention, early intervention and treatment.

F. Maximize the use of Medicaid and KidCare.

1. Develop a targeted funding plan to maximize the use of Medicaid, including EPSDT, and the strategic use of state dollars as matching funds. The plan should include identification of previously untapped or under-utilized sources of state and local resources, including 708 Mental Health Boards, to be used to match federal Medicaid dollars.

2. Claim Medicaid reimbursement for Individual Care Grants (ICG) for children via the inpatient psychiatric services for individuals under 21.[iii] The ICG reimbursement should be deposited in the Children's Mental Health Fund.

3. Require Screening Assessment and Support Services (SASS) prior to all admissions of children for psychiatric hospitalizations that are funded by Medicaid. Increase SASS capacity to conduct these screenings and use the savings, obtained by serving children in the community instead of psychiatric inpatient hospitalization, to fund children's mental health services.

---

iii This is allowable under the existing state Medicaid Plan and would capture additional Medicaid Federal Financial Participation (FFP) claims of approximately $12 million per fiscal year, plus up to the two previous fiscal years.

4. Capitalize on federal Medicaid reimbursement to federally qualified community health centers (FQHCs) by providing behavioral health services to children in these settings.

5. Improve Medicaid reimbursement for prevention, early intervention and treatment services:

   a. Recognize diagnoses for young children described in DC:0-3[iv] and pay for mental health services for children with any of these diagnoses.

   b. Clarify for providers the diagnoses that create eligibility for children to obtain Medicaid services.

5. Expand the number and type of providers (e.g., licensed clinical social workers and psychologists, licensed clinical professional counselors, and nurses) who are eligible to receive reimbursement for assessment and treatment services under Medicaid.

6. Modify the state Medicaid plan to extend coverage for psychosocial services to pregnant women beyond the current limit of 60 days post-partum.

7. Change the Illinois KidCare and Medicaid eligibility procedures to allow for self-attestation of a family's financial circumstances in lieu of current financial documentation requirements.

8. Change the state's Medicaid plan to obtain federal reimbursement for administrative costs for coordination of systems.

G. Continue and expand the funding of school-based and school-linked community health centers.

H. Strengthen the private funding of children's mental health services.

1. Broaden the current Illinois parity law to require private insurance companies to cover all mental health diagnoses and services of children ages 0-18 years.

2. Explore methods of increasing other private sector support.

IV. Build a Qualified and Adequately Trained Workforce with a Sufficient Number of Professionals to Serve Children and Their Families

A. Expand and strengthen the professional preparation and workforce of children's mental health professionals. Efforts should include:

1. Expand the workforce of individuals trained to provide mental health consultation to programs, providers and treatment services for children ages 0 - 18 years and their families.

   a. Work with institutions of higher education to expand the number of programs that offer coursework and specialized tracks in children's mental health.

2. Develop incentives to expand and diversify the number of mental health professionals who provide mental health consultation and treatment to children, particularly underserved populations (e.g., rural, migrant, bilingual, inner-city), in early childhood programs, schools and communities.

---

iv The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) was developed by Zero to Three: National Center for Infants, Toddlers, and Families to identify and treat mental health and developmental disorders in very young children.

3. Collaborate with institutions of higher education to ensure that the training of mental health professionals includes core competencies in children's mental health, and social and emotional development.

4. Expand university offerings through extension programs that reach rural communities.

5. Develop incentives to attract not only bilingual, but bicultural professionals.

6. Increase the number of mental health providers available to serve children and adolescents in Chicago and downstate.

7. Provide ongoing and evaluated training to current "front-line" workers regarding evidence-based practices in children's mental prevention, early intervention and treatment.

B. Expand and strengthen the professional preparation of primary care providers (e.g., pediatricians, family physicians), educators, paraprofessionals and others that come in contact with children and their families, in the social and emotional development of children.

C. Improve relevant certification requirements in key professions to ensure a qualified and adequately trained workforce. This includes:

1. Support and promote an endorsement system for various levels of early childhood mental health practitioners and encourage relevant programs to require the endorsement, once available.

D. Assure continuing education, training, and staff development.

1. Work with institutions of higher education, professional associations, and state agencies to increase opportunities and requirements for training regarding children's mental health, including the impact of exposure to violence, through pre-service, in-service and ongoing professional development for early childhood, health care, and community behavioral health care providers, teachers, paraprofessionals, and others.

2. Provide information and training to staff in family and adult-focused programs regarding early childhood development, and programs, services, and resources available in the community to families with young children (e.g., Head Start and Early Head Start, Healthy Families, EI, WIC, Parents Too Soon, Early Childhood Education Block Grant).

3. Build on and strengthen efforts to infuse early childhood mental health principles and relationship-based service strategies into pre-service and ongoing training of Special Education and Early Intervention providers.

4. Build on and strengthen efforts to provide staff development on the planning and implementation of school-wide, classroom-based activities that focus on building assets and addressing problems in school-age children.

a. Create training and staff development opportunities that help establish positive and supportive relationships among all school staff, students and parents.

5. Develop a statewide database of qualified early childhood mental health practitioners and make it available to local communities.

V. Increase Public Education and Awareness

A. Develop a comprehensive, multicultural, and multi-faceted public awareness campaign to reduce the stigma of mental illness; educate families, the general public and other key audiences about the benefits of children's social and emotional development; and inform parents, providers and others about how to access services.

1. Include general information about mental health, the prevalence of problem behavior, the impact of exposure to violence, and evidence-based practice highlighting successful school and community progress.

2. Engage parents, caregivers, children and others in the development and design of the campaign.

3. Develop and disseminate tailored educational materials that are targeted to: parents, early care and education programs and providers, policy makers, the business community, families and individuals who live in geographically isolated regions of the state, have low literacy skills, or are non-English speakers, culturally diverse communities, and the general public.

VI. Create a Quality-Driven Children's Mental Health System with Shared Accountability Among Key State Agencies and Programs

A. Establish the capacity to conduct ongoing assessments of the mental health needs of children ages 0 - 18 years and their families.

1. Create and implement an early childhood survey to periodically assess the social and emotional development, and mental health needs of young children.

2. Coordinate existing youth surveys (e.g., IL Youth Risk Survey, Youth Risk Behavior) for middle and high school students and communicate the results in a timely fashion.

3. Integrate an examination of protective factors, in addition to risks, for children's mental health into existing youth surveys.

B. Develop outcome indicators and benchmarks, with links and integration to early childhood and school standards, for assuring children's optimal social and emotional development, and improving overall mental health.

1. Promote the use of common or comparable indicators and benchmarks by early childhood programs, schools, community-based providers, and others.

2. Require government-administered early childhood programs and schools to review program requirements and policies, and track outcomes related to the statewide benchmarks.

3. Establish a social and emotional development learning standard within the existing Illinois Learning Standards.

   a. Create a separate learning standard for the social and emotional development of school-age children.

   b. Cross-walk existing standards, building on existing evidence-based work, for their connection and integration to children's social and emotional development.

4. Integrate social and emotional learning as part of the student report card and school report card.

C. Improve accountability, data tracking and reporting for children's mental health in relevant programs and services.

1. Institute contract and monitoring changes to increase the accountability of current children's mental health providers.

2. Develop a statewide data tracking and reporting system to collect information on key indicators of children's social and emotional development, and mental health status.

3. Develop policies and protocols for the sharing of databases among relevant state and local agencies.

4. Explore the development of uniform reporting forms and test in select programs for the tracking, reporting and planning of services.

VII. Invest in Research

A. Establish a Children's Mental Health Research and Resource Center(s) to collect and facilitate research on best practices and model programs, share information with Illinois policymakers, practitioners and the general public, develop training and educational materials, provide technical assistance, and other key activities.

B. Provide funding for culturally competent and clinically relevant research, including longitudinal studies that: address evidence-based practices in prevention, early intervention, and treatment; are translated into practice standards and policy implications for key groups; and are used to improve programs and services.

C. Develop and conduct process and outcome evaluations that measure changes to the children's mental health system and child outcomes as a result of implementing recommendations from the Illinois Children's Mental Health Task Force.

Appendix A:

Public Systems, Services and Programs That Serve Illinois Children

Health Insurance for Children

The Illinois Department of Public Aid (IDPA) is dedicated to improving the health of Illinois' families by providing access to quality healthcare and enforcing child support payment obligations for Illinois' most vulnerable children.

Kidcare

Kidcare offers health care coverage to eligible children through age 18 and pregnant women, and helps pay the premiums of employer or private health insurance plans. Services are available at no cost or at low cost depending on income and family size. Covered services include doctor and nursing care, shots and preventive care, hospital and clinic care, laboratory tests and x-rays, prescription drugs, medical equipment and supplies, medical transportation, dental care, eye care, psychiatric care, podiatry, chiropractic care, physical therapy, mental health and substance abuse services. Pregnant women also receive prenatal care and medical services.

Specific covered mental health services include: assessment/ evaluation, emergency care, inpatient psychiatric care, nursing facility care, outpatient hospital/ psychiatric clinics, doctors, laboratory services, prescription drugs, counseling by a doctor or at a community mental health center or hospital and group therapy. Services may be limited to certain types of providers.

Healthy Kids

Children participating in the Department's Medical Assistance or Kidcare Program are encouraged to receive preventive and comprehensive health services designed to provide early discovery and treatment of health problems (commonly known as Early and Periodic Screening, Diagnosis and Treatment or EPSDT). The Department recommends that children receive preventive health care at regular intervals and will reimburse providers for well child medical services at the recommended intervals or more often as needed. The program's covered risk assessments include mental health and substance abuse screenings.

School Based Health Services Program

The School Based Health Services Program allows Local Education Agencies (LEAs) to enroll as Medicaid providers and to claim federal reimbursement for certain health services provided to eligible special education students. The program has two parts: fee- for-service activities and administrative outreach activities. Fee-for-service activities include direct services provided by medical practitioners to a special education student or the student's parent on behalf of the student. The program allows for reimbursement for certain psychological services necessary for the development of the Student's IEP or active treatments with the intent to reasonably improve the student's physical or mental condition. Mental health services must be provided by a Type 73 School Psychologist or a Psychologist Intern with ISBE approval.

Services for Infants and Toddlers with a Disability or Developmental Delay

Children under 36 months of age who have a disability or developmental delay are eligible for services through the Illinois Early Intervention Services System, Department of Human Services which is defined in Part C of the federal Individuals with Disabilities Education Act (IDEA). In order to be eligible for services, children must have a delay in at least one of the following areas: cognitive development; physical development, including vision and hearing; language and speech development; psychosocial development; or self-help skills. Children at-risk of a developmental delay as defined by rule are also eligible.

Families access services through a regional point of entry known as the Child and Family Connections (CFC) office. Twenty-five CFCs located throughout the state provide intake coordination, assist with eligibility determination, and coordinate development of an initial Individualized Family Service Plan (IFSP) which outlines the services needed by the child and family. A statewide network of enrolled EI providers provide a range of services that include: assistive technology devices and services; audiology, aural rehabilitation and other related services; developmental therapy; medical services for diagnostic/evaluation purposes; nursing; nutrition; occupational, speech language and physical therapies; psychological and other counseling services; service coordination; social work and other counseling services; transportation; and vision services.

Developmental evaluation, assessment, IFSP development, and service coordination are available at no cost to families. EI services are authorized and provided in accordance with the eligible child's IFSP, in the most natural setting for the child and family. Families may be charged a fee for some ongoing EI services, based on ability to pay. If a family has private insurance, they must use insurance for the services.

To focus on the healthy social and emotional development of infants and toddlers with disabilities and delays, pilot projects were initiated in the fall of 2002. Three CFC pilot sites were funded to hire a part-time early childhood mental health specialist. All three sites have begun assessing children's social and emotional development as part of the intake process. Follow-up evaluations are conducted when appropriate and services are incorporated into a child's IFSP as needed. The specialists provide individual case consultation to service coordinators and EI providers, and ongoing consultation to the CFC manager, for improving her capacity to provide similar supervision and support to service coordinators. The specialist also provides bimonthly integrated service delivery workgroups for providers and service coordinators on how to instill relationship-based practices and early childhood mental health strategies into their work with children and families.

Special Education Services

Under IDEA, a free and appropriate public education (FAPE) is required for all students with disabilities, ages 3 to 21. Part B of IDEA specifically addresses the special education services available for all children ages 6 to 21. Under Part B, students may attend high school until receipt of their high school diploma or until the end of the school year of their 21st birthday, whichever is earlier. The Office of Special Education Programs, Illinois State Board of Education, administers the state's special education program (Part B). During the 1999-2000 school year, 263,028 Illinois students were served in this program.

Access to special education services is available through local school districts. A child can receive a referral for a special education evaluation by a parent or educator. An eligibility evaluation is conducted by the school district. For those children deemed eligible for special education services, an Individualized Education Program (IEP) is developed and progress towards IEP goals is reviewed annually. Services that are covered under the IEP are similar to those provided under Part C, and also include supplementary aids and services provided by the school in order to meet identified developmental and educational goals, as well as the timing and frequency of when services will be provided. Additional services include assistive technology, behavioral intervention plans, extended school year services, home-based support, transportation services and transition services.

Families access services through their local school districts. Families and schools must decide together on the child's least restrictive environment for receiving special education services, such as regular education, resource room, self-contained room, separate day school, residential program, or home/hospital program. There are approximately 11 special education Part B disability categories, including emotional disturbance, learning disabilities, physical disabilities and other mental disabilities.

Services for Children with Developmental Disabilities

Children with developmental disabilities are provided an array of services, including in-home and residential services, through the DHS Office of Developmental Disabilities (DD). Local service providers are funded by the Office of DD to provide services for prevention and health promotion, and treatment. Prevention and health promotion efforts focus on in-home respite and family home maintenance. They are designed to assist families caring for children with developmental disabilities in their own homes by providing temporary relief to the primary caregiver.

Eighteen independent service coordination agencies located throughout the State receive grant funding from the Office of DD to provide information and referral, assessment, and other case management services for children and adults seeking services. Because a considerable number of children are being served in out-of-state residential settings, these placements are currently being reviewed in order to return children to in-state programs closer to their family homes.

All services for children with developmental disabilities are supported with State General Revenue Funds, except for Skilled Pediatric care provided in Intermediate Care Facilities (ICFs) which is funded through Medicaid. Funding for in-home respite services is limited to legislative appropriations and is therefore subject to availability. The Office of DD oversees the allocation of respite services.

Children's Mental Health Services

The DHS Office of Mental Health (OMH) is legislatively identified as the state's mental health authority, encompassing: the direct provision of mental health services through state hospitals and contracts with private sector hospitals, oversight of private not-for-profit agencies that provide community mental health services, and policy and program development for state agencies that either purchase or deliver mental health services. Under OMH-established guidelines, individual, family and group interventions for children and adolescents are defined as: crisis intervention, case management, Screening, Assessment, and Support Services (SASS), day treatment, medications management, and other endorsed programs or interventions.

Children with a serious mental illness or severe emotional disturbance often suffer functional impairments in multiple areas such as family, housing, work, school, or community that require immediate and ongoing services. Currently, OMH services target children who are 3-17 years old and defined as having I + (II or III) + IV from the categories below:

I. The diagnosis of a significant DSM-IV diagnosis;

II. A history of six months of treatment in a community setting or two psychiatric hospitalizations in twelve months;

III. A significant impairment in social, occupational, school, community or family functioning;

IV. A likely response to treatment either by diminished impairment or prevention of further impairment.

More than 150 statewide community mental health centers and other mental health providers receive funding from OMH; approximately 100 receive support exclusively for child and adolescent mental health services. OMH provides inpatient psychiatric hospitalization in 2 State Operated Hospitals; however, in many regions of the state, these services are provided through contracts with numerous private sector community hospitals or medical centers. All OMH-funded community agencies are certified to bill Medicaid for services.

In cases where a child may require a level of care only available in a residential treatment setting, families can apply to OMH for an Individual Care Grant. For eligible families, this grant pays for residential treatment or to assemble an intensive community-based program that maintains a child in a less restrictive environment. OMH also funds programs tailored to meet the mental health needs of high-risk youth or high-need populations such as those in juvenile courts, detention centers, who run away or are homeless, and children and families from Chicago Public Housing.

Health Prevention and Promotion Programs and Services

Children, adolescents and their families are provided a range of programs and services to promote children's overall health and social and emotional development through the Office of Family Health. These programs and services include:

- Developmental Screening for Young Children. Staff of local Family Case Management (FCM), WIC and Teen Parent Services will be trained to conduct developmental screening as a routine part of program operations. Regional nursing consultants will provide additional assistance. Children who show evidence of delay will be referred to the Early Intervention Services System for a more in-depth assessment.

- The Healthy Families Illinois Program seeks to prevent child abuse and neglect through frequent voluntary home visits that provide parenting skills education to high-risk families. New parents are assessed for risk of child abuse or neglect; those who are at risk can elect to participate in the program. Home visits are designed to help families promote healthy child development, strengthen the parent-child relationship, support parents as children's first teachers, and reduce family isolation. The program has contributed to the recent decline in child abuse and neglect.

- HealthWorks of Illinois (HWIL) Program, a component of FCM, is a collaborative effort of DHS and the Department of Children and Family Services (DCFS). HWIL ensures that children under age six who are in DCFS custody receive comprehensive, quality health care. All children taken into custody by DCFS receive an initial health screening within the first 24 hours, preferably before placement with a substitute caregiver. Within 21 days after the initial health screening, new wards receive a comprehensive health evaluation. HWIL also ensures that these children receive ongoing primary and specialty care appropriate to their needs.

- High-Risk Infant Follow-up Program, a component of FCM, serves all infants who have a serious medical condition. Statewide services are provided by registered nurses, and follow-up may continue until the child's second birthday. Follow-up services are designed to promote optimal growth and development, teach a family how to care for the high-risk infant, prevent complications, decrease morbidity and mortality, decrease stress and potential for abuse, and ensure early identification and referral for further treatment and evaluation.

- Immunization. The WIC program serves more than 40 percent of the infants and toddlers in the state; all WIC children are eligible for immunization services. Local WIC agencies, most of which are local health departments, receive regular reports on the proportion of infants and toddlers who are fully immunized. Local users are encouraged to query their Cornerstone databases for information on children who are not fully immunized and then conduct follow-up activities to provide needed immunizations.

- Newborn Hearing Screening Program, administered by DHS, the Department of Public Health (DPH) and the University of Illinois at Chicago Division of Specialized Care for Children (DSCC), identifies newborns at risk of having hearing loss prior to hospital discharge. Approximately 500 infants with significant hearing loss are born in Illinois each year. Hospitals are required by state law to screen infants for hearing loss and refer infants with suspected hearing loss to DPH. A child's parents and physician are notified of the test results and provided with information about follow-up testing. DSCC pays for diagnostic testing if a family is unable to afford it or they are uninsured. Infants who are diagnosed with significant hearing loss are referred as indicated to DSCC and the Early Intervention Services System.

- **Parents Too Soon (PTS) Program** serves new and expectant teen parents to help them develop nurturing relationships with their children, reduce the rate of subsequent pregnancy, improve the health and emotional development of the teen, enhance self-sufficiency, and promote the healthy growth and development of the children of the teen parents. Services include weekly home visits and monthly peer group meetings.

- **School-Based/School-Linked Health Centers** provide physical and mental health services to students in grades pre-K through 12th grade, children of adolescents, and children in Head Start programs who are otherwise unable to receive medical care when they need it, and whose families cannot afford health care. Services are provided within the schools by licensed professional staff or through referral to other local health care providers. Approximately eight percent of the students served receive mental health services; visits for mental health services account for 13 percent of all visits. Each local community determines the services to be provided by the center. DHS currently funds 31 sites throughout the state.

- **The Teen Parent Services (TPS) Program** is offered to young parents (under age 21), who are receiving TANF, KidCare or Food Stamps and who do not have a high school diploma or GED. TPS assists these parents in enrolling and staying in school, and thus becoming more self-sufficient. The program also focuses on prevention of subsequent pregnancies and development of parenting skills. Participation is required of TANF-eligible teen parents and offered to teen parents who are eligible for KidCare.

Child Care Assistance

The Illinois Child Care Assistance Program, administered by the DHS Bureau of Child Care and Development, provides assistance with child care expenses to low-income families who are working or participating in education and training activities. The program also provides supports to maintain or improve the quality of child care - care that contributes to children's healthy growth and development.

Parents can access services through the use of certificates or contracts. Under the certificate system, eligibility is determined by one of 17 child care resource and referral agencies (CCR&R) located throughout the state that are funded by DHS. Through the site-administered contract system, parents may apply for licensed care from a statewide network of nearly 200 contracted providers. Eligibility is determined on site by the contracted provider.

CCR&R agencies provide assistance to parents looking for child care providers. The agencies maintain a database of all licensed providers in their service area and many license-exempt providers. CCR&Rs also provide training and professional development opportunities for child care providers as well as assistance with accreditation and grants for quality improvement activities.

The Illinois Network of Child Care Resource and Referral Agencies (INCCRRA), with funding from DHS, manages the T.E.A.C.H. program, a scholarship program for child care workers returning to college, and the Great START program, a wage supplement program for child care workers with education levels that exceed licensing requirements for their position. INCCRRA also develops statewide training programs for providers licensed through the Illinois Trainers Network. INCCRRA is currently developing two training curricula - one on developmental screenings for use in child care settings to help providers identify children that might have a developmental delay and the other on services for children with special needs in inclusive settings. Other related services include:

- **Mental Health Consultation for Child Care** - Under a new initiative, the Office of Family Health is working with the Office of Mental Health, the Child Care Program and the Early Intervention Services System to make behavioral health training and consultation available to child care providers. A child development specialist from a community mental health center would provide training to child care providers on a regional basis and be available to consult with individual child care providers on the management of difficult behavior and appropriate referral for additional services.

- **The Healthy Child Care Illinois Program** is designed to link child care facilities and health and other service providers, improve access to health services by children and families, and improve the health status of children, families and child care providers. The Office of Family Health and the Office of Child Care and Family Services are collaborating to support a statewide network of 24 nurse consultants located in the state's CCR&Rs. Nurse consultants work to improve the healthfulness of child care settings and to link children to other health and social service programs and services in the community. This project is supported by the Health System Development in Child Care grant, and by more than $1.8 million in federal maternal and child health (Title V) and Child Care Development funds.

Head Start/Early Head Start

Head Start and Early Head Start are comprehensive child development programs which serve children from birth to age 5, pregnant women, and their families. They are child-focused programs with the overall goal of increasing the school readiness of young children in low-income families. Funds are awarded by the federal Head Start Bureau, Administration for Children and Families, Department of Health and Human Services directly to local public agencies, private organizations, Indian Tribes and school systems for operating Head Start programs at the community level.

Grantee and delegate agencies provide a range of services in the areas of education and early childhood development; medical, dental and mental health; nutrition; and parent involvement. Eligibility is based on federal poverty income guidelines; families with incomes up to 100 percent of the federal poverty level are eligible to participate in the programs. Early Head Start serves pregnant women and families with children under the age of 3; Head Start serves eligible families with children ages 3-5.

Educational Supports for Students

Positive Behavior Interventions and Supports (PBIS), administered by ISBE, is a research-based systems approach designed to promote the mental health and social competence of all students. Over 300 Illinois schools are currently implementing the program which teaches and reinforces pro-social behaviors of students in all school settings. School teams use problem-solving techniques to provide supports to students who require more than a school-wide instructional approach; students with more intensive needs receive comprehensive wraparound plans that provide individualized supports and interventions for them and their families. PBIS enables schools to prevent behavior problems and quickly identify students at-risk of or with significant emotional and behavioral needs. This results in safer, more effective school environments that can lead to increased learning and academic performance.

PBIS was incorporated into the ISBE Emotional Behavioral Disabilities (EBD) Network in 1998 to build the capacity of schools to implement prevention and early intervention efforts. EBD originated in 1990 as community-based system of care program with demonstration sites that provided family-centered interagency wraparound teams for students with significant emotional and behavioral needs, and their families. Today, an EBD/PBIS Network provides training, evaluation, technical assistance and hands-on coaching support to schools, families and community agencies. PBIS data suggests that participating schools are reporting higher rates of effectiveness with comprehensive wraparound plans for those students with significant emotional and behavioral disturbances.

Local schools, districts, and Special Education Cooperatives have identified over 200 local PBIS coaches who are being trained to lead their schools and districts in developing skills in areas including: instruction of pro-social behavior, development of student-specific support plans, analysis of school-wide discipline trends, and school-based wraparound, including supports for families and connections with mental health and other community-based supports. Results indicate that school-wide instruction in pro-social behaviors reduces discipline problems and improves learning environments in schools. Increases in academic performance are indicated as well.

Substance Abuse Prevention

The Student Assistance Program (SAP), administered by the Office of Prevention, is an identification and referral program for students experiencing problems. Community-based providers deliver technical assistance to local school teams that have received SAP training through ISBE. These providers assist school teams to develop their programs in areas including connecting schools with appropriate referral sources and training other school personnel about substance abuse issues.

Through a network called the Illinois Network to Organize and Coordinate the Understanding of Community Health (InTouch), offices provide technical assistance and training, and serve as a communication link for coalitions, organizations and groups. InTouch offices serve as a resource for communities interested in addressing substance abuse prevention and build community capacity to address conditions related to youth substance abuse. Prevention First, Inc. (PFI) is the statewide clearinghouse and library for substance abuse prevention materials which are available to any Illinois resident free of charge. The lending library houses books, curricula, video tapes, CD's and other materials related to substance abuse and related issues.

In addition to these efforts, Eastern Illinois University provides technical assistance and training to two and four year, public and private higher education institutions. The Lighthouse Institute coordinates the administration of the Illinois Youth Survey, a survey of middle school and high school students regarding drug use and attitudes.

Violence Prevention

The Illinois Violence Prevention Authority administers several programs designed to prevent violence and assist children and families exposed to violence.

- **Safe from the Start** provides grants to coalitions in six sites throughout Illinois to develop, implement and evaluate community-based models for identifying and providing services to young children (ages 0-5) who have been exposed to and traumatized by exposure to violence in the home and in the community. Sites also provide prevention education and professional development on the effects of exposure to violence on children.

- **Safe to Live** provides grants to broad-based community coalitions to conduct comprehensive needs assessments, develop strategic plans, and implement coordinated approaches that address all forms of interpersonal violence. The sites may identify children's social and emotional development, and mental health needs as one of their priority implementation issues.

- **Safe to Learn**, a program that was established in FY '01 but not funded in FY '03, provided grants to school districts to conduct school safety programs that address school security, violence prevention, school personnel training, and crisis management. Many districts used funds to hire extra counselors or purchase mental health services for high-risk children. Districts also used their funds to implement social and emotional development programs in the areas of problem-solving, conflict resolution, and anger management.

Youth Services and Juvenile Justice

Youth Services and Juvenile Justice programs, which are administered by the Department of Human Services, Division of Community Health and Prevention, Office of Prevention, offer services that support families in crisis, prevent juvenile delinquency, and divert youth at risk of involvement in the child welfare, juvenile justice or corrections systems. Local community-based providers work with their community to determine local community needs related to at-risk youth. If a community determines that youth services program activities need to encompass mental health services, local provider(s) work with community mental health service providers to provide these services.

- **Teen REACH/AmeriCorps** - Through prevention-focused activities offered during non-school hours, Teen REACH programs seek to expand the range of choices and opportunities that enable, empower and encourage youth to achieve positive growth and development, improve expectations and capacities for future success, and avoid and/or reduce risk taking behavior. Teen REACH programs are encouraged to collaborate with other youth development initiatives and social service agencies in their communities, including mental health agencies. While mental health services are not provided at Teen REACH program sites, staff are encouraged to make referrals to appropriate mental health care professionals.

- **Communities for Youth (CFY)** serves youth ages 10-7 who are involved in risk-taking behavior (e.g., gang involvement, violence, drugs), have been station adjusted (i.e., arrested but not referred to court), or placed on probation supervision to prevent further involvement in the Juvenile Justice System, and youth who have been placed on probation and are at risk of violating probation or re-offending. The three priority areas for programming are: prevention (e.g., tutoring, mentoring and after-school programs), diversion (e.g., day/evening reporting centers, teen court and mediation) and intervention (e.g., similar to diversion services but for those youth who have been adjudicated delinquent).

- Community Youth Services (CYS) serves youth who are at risk of involvement in the Juvenile Justice System. It is designed to mobilize communities in collaboratively designing and operating programs aimed at reducing and preventing juvenile delinquency, and addressing other youth problems. CYS programs also focus on increasing community ownership and involvement, and promoting positive societal norms. Communities determine those youth and families to target, and voluntary community committees agree on the activities to address identified juvenile issues.

- Comprehensive Community-Based Youth Services (CCBYS) is a statewide program for youth ages 10-17 who are at risk of involvement in the child welfare and/or juvenile justice system. CCBYS provides at-risk youth with a continuum of services according to their needs, with the overarching goal of family preservation and reunification or independence, depending upon a youth's needs. Services are directed at assuring that youth who come in contact with the child welfare or juvenile justice systems have access to community, prevention, diversion, emergency or independent living services. A 24-hour crisis intervention response system is available in emergency situations for referrals from the police, courts and the DCFS Child Welfare and Protection staff.

- Delinquency Prevention (DP) serves youth ages 12-17, who have committed a delinquent offense and are referred by local law enforcement and probation departments. DP is designed to divert youth who have committed a delinquent offense from deeper involvement in the juvenile justice system. Program services include community outreach, advocacy, individual and family counseling, intake assessment, employment and recreation.

- Homeless Youth (HY) program serves youth who are 20 years of age or younger who cannot return home and lack the housing and skills necessary to live independently. HY provides services that help homeless youth transition to independent living and become self-sufficient. The program strives to meet the immediate survival needs (food, clothing, and shelter) of youth and assist them in becoming self-sufficient. HY provides a range of services to meet youth needs including: emergency shelter, transitional services, drop-in center/outreach, and services for youth who do not have children.

- Release Upon Request (RUR) serves youth ages 12-17 in Cook County who have been ordered to be released from the Cook County Temporary Juvenile Detention Center, but remain there because a parent, guardian or custodian has failed to accept custody. The program ensures that the youth is removed from detention within 24 hours of referral, upon which efforts then turn to reunifying the family.

- Unified Delinquency Intervention Services (UDIS) is focused on youth between the ages of 13 and 17 who are at risk of a Department of Corrections placement. The program is designed to divert them from further involvement in the criminal justice system. UDIS providers assess each youth in the program, develop an intervention plan, and provide community-based intensive services to meet the individualized needs of the youth. Services can include case management; individual, family and group counseling; tutoring; and mentoring.

- YouthBuild (YB) enrolls youth and young adults aged 16-24 who have dropped out of school, are unemployed and have limited job skills. YB focuses on academic goals while also helping youth to develop job skills by building homes for low-income families. The program is a year-long, highly demanding program that offers young people an opportunity to build their futures and their communities through education, leadership development, job training, and the rehabilitation and production of affordable housing.

Juvenile Justice

The Juvenile Justice Program of the Department of Human Services is a categorical grant program funded pursuant to the Juvenile Justice and Delinquency Prevention Act (42 USC 5601 et. seq.) through the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. The Department of Human Services is responsible for administering activities in partnership with the Juvenile Justice Commission. Illinois receives funding for the following sub-grant programs:

- Title II Formula Grant Programs support activities that include establishing alternatives to secure detention for youth involved in the juvenile justice system, providing training for juvenile justice professionals, transporting youth in need of secure detention to juvenile detention facilities, and assisting jurisdictions in assessing and planning to meet their secure detention needs. Formula Funds also support communities' efforts to address chronic truancy without resorting to use of secure detention for non-offender youth.

- Title V Delinquency Prevention Program funds assist communities in identifying the factors that place children at risk of delinquency, substance abuse and other negative behaviors and developing comprehensive delinquency prevention plans. By identifying delinquency risk factors and developing strategies to strengthen the protective factors that decrease the likelihood of engaging in delinquent or other negative behavior, Title V programs can reduce the number of youth entering the juvenile justice systems. Federal regulations limit these grants to general-purpose units of local government.

- Challenge Grant Programs are intended to shape and guide juvenile justice policy decisions through research and/or demonstration projects in juvenile justice. The Illinois Juvenile Justice Commission has established activities for Challenge Grant research, which include examining access to legal counsel, gender equity, detention screening processes, mental health needs of youth in and leaving the juvenile justice system, alternatives to suspension or expulsion from school, and public perceptions of the juvenile justice system.

Child Protection and Social Services

A wide variety of child protection and social services are provided to more than 119,000 children and families each year by the Department of Children and Family Services (DCFS). This includes services to approximately 32,000 children currently living in substitute care. In order to meet the diverse needs of its clients, DCFS also contracts with approximately 1,500 private providers of services, ranging from foster care to counseling and psychiatric services.

More than 35,300 organizations and individuals that provide child care or child welfare-related services are licensed by DCFS, resulting in a system capacity to handle more than 310,000 clients. The Department licenses approximately 2,800 day care centers, 9,640 day care homes, 22,700 foster homes, 111 institutions, 260 agencies, 158 group homes and five emergency shelters.

Key functions and services provided to children and their families by DCFS include the following:

- protects and promotes the welfare of children,
- provides social services to children and their families,
- provides grants for comprehensive community-based services to reduce family dysfunction,
- provides adoption assistance to persons who adopt special needs children,
- prevents, remedies or assists in the solution of problems which may result in the neglect, abuse, exploitation or delinquency of children,
- prevents the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems and preventing break-up of the family where the prevention of child removal is desirable and in the best interest of the child,
- returns children to their biological parents when it is safe to do so,
- places children in adoptive homes and in subsidized guardianships when returning a child to a biological parent is no longer an option,
- provides shelter and independent living services for homeless youth, and
- provides screening, assessment, and treatment services to wards and family members with behavioral health needs.

Social Service Programs

The Title XX Social Services Block Grant (SSBG), administered by the DHS Bureau of Title XX Social Services, is designed to establish and develop social service programs that respond to the needs of local communities. Children's mental health services covered under this block grant include treatment/habilitation, community maintenance, case management, and social adjustment and rehabilitation services. Services are provided through agreements with public and private community-based organizations. Children and adults are eligible for SSBG services based on need, as defined by service and eligibility criteria. For TANF, children and families must meet the 200% of poverty eligibility requirement.

The Multiple Agency Resources Pool was created through the SSBG Donated Funds Initiative to fund selected cases identified by the Community and Residential Services Authority (CRSA). These child/youth cases are selected for payment from the Pool if, through the CRSA Dispute Resolution Process, it is determined that no single agency or group of agencies is responsible for or willing to provide services. Those agencies are DHS, Department of Corrections, Department of Children and Family Services, Department of Public Aid, and the Illinois State Board of Education. All payments for CRSA-approved cases are issued by DHS through a community services agreement to the institution providing the services and residential care. Residential care services are provided on a short term basis.

Substance Abuse Early Intervention and Treatment

The Office of Alcoholism and Substance Abuse (OASA) provides substance abuse early intervention and treatment to children and adolescents, based on placement criteria that are used for all clients - emotional, behavioral or cognitive conditions, and complications. OASA contracts with non-profit community service providers to offer services including assessment, psychiatric evaluation, early intervention, community intervention, outpatient, residential and case management services. Every OASA-funded provider with an adolescent treatment license can bill for psychiatric evaluations. Based on the services offered and capacity of the provider, these providers either deliver any necessary mental health services or refer the adolescent to an appropriate agency. In FY 2000, OASA provided 17,002 substance abuse service units to 564 individual youth (ages 12-17 years) identified as dually diagnosed.

OASA funds several new and ongoing efforts targeted to children and adolescents. Ben Gordon Center in DeKalb and Family Service of McHenry County, received funding in FY 2001 for adolescent psychiatric evaluations. Rosecrance Health Network in Rockford receives funding to serve dually diagnosed adolescents and their families who can benefit from a specially designed substance abuse treatment program that addresses their multiple issues. unds for 21 beds in the Maryville Academy, a residential center for dually diagnosed adolescents. In addition, OASA funds childcare residential services that allow infants and children to stay with their mothers while the women receive substance abuse treatment. Multiple services are available for these children, including developmental assessments and referrals for necessary services. For the past two years, Metro OASA and the Office of Mental Health Child and Adolescent Workgroup have brought together mental health and substance abuse providers to enhance collaboration and services for adolescents.

SELECTED CHILDREN'S MENTAL HEALTH RESOURCES

FEDERAL AND NATIONAL RESOURCES

1. Bazelon Center for Mental Health Law - Information on children's mental health, including the report, *Making Sense of Medicaid for Children with SED* can be accessed at http://www.bazelon.org/

2. *Bright Futures in Practice: Mental Health Practice Guide* (2002) is available at http://www.brightfutures.org

3. Center for Health and Healthcare in Schools provides numerous resources on school health and mental health in schools at http://www.healthinschools.org

4. Center for Mental Health in Schools, University of California Los Angeles - Resources including training materials, special reports and technical assistance samplers are available at http://www.smhp.psych.ucla.edu/

5. The Child Mental Health Foundations and Agencies Network - Information including the report *A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed in School* can be accessed at http://www.nimh.nih.gov/childhp/monograph.pdf

6. Collaborative for Academic, Social and Emotional Learning (CASEL) - Resources including the report *Safe and Sound: An Educational Leader's Guide to Evidence-Based Social and Emotional Learning Programs* can be accessed at http://www.casel.org/

7. U.S. General Accounting Office - *Child Trauma and Mental Health Services report to Congress (GAO-02-813)* can be accessed at http://www.gao.gov/

8. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families (2000) is available at http://www.nap.edu/books/0309069882/html/

9. National Academy for State Health Policy has resources on Medicaid and SCHIP, and early childhood including the report, *Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System* at http://www.nashp.org

10. National Center for Children in Poverty has numerous resources including the publications *Making Dollars Follow Sense: Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children, and Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four-Year-Old Children* available at http://www.nccp.org/

11. National Conference of State Legislatures has numerous resources for state policymakers including, *Mental Health Services for Children: An Overview,* available at http://www.ncsl.org

BEST COPY AVAILABLE

12. National Governors Association, Center for Best Practices - Information on children's health, Medicaid and SCHIP, TANF, youth development, school health, extra learning opportunities and other issues can be accessed at http://www.nga.org/

13. National Institute of Mental Health. This web site contains background information, educational materials and research reports on mental health issues, as well as links to national children's mental health resources. Information can be accessed at http://www.nimh.nih.gov/publicat/childmenu.cfm

14. National Mental Health Association - Numerous reports are available online at http://www.nmha.org/, including:
    - *Promoting Children's Mental Health*
    - *Children's Mental Health Matters*
    - *Caring for Every Child's Mental Health*

15. The National Technical Assistance Center for Children's Mental Health has numerous resources including, *Funding Early Childhood Mental Health Services and Supports* available at http://www.georgetown.edu/research/gucdc.cassp.html

16. The Office of the Surgeon General, U.S. Department of Health and Human Services. The following reports covering children's mental health and related issues can be accessed at http://www.surgeongeneral.gov/sgoffice.htm
    - *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*
    - *Mental Health: A Report of the Surgeon General*
    - *Mental Health: Culture, Race and Ethnicity*
    - *The Surgeon General's Call to Action to Prevent Suicide*
    - *Youth Violence: A Report of the Surgeon General*

17. *Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs*, developed by the Social Development Research Group, University of Washington can be accessed at http://journals.apa.org/prevention/volume5/pre0050015a.html

18. *The Prevention of Mental Disorders in School-Aged Children: Current State of the Field* (2001), developed by the Prevention Research Center for the Promotion of Human Development, Pennsylvania State University, can be accessed at http://journals.apa.org/prevention/volume4/pre0040001a.html

19. President's New Freedom Commission on Mental Health - Reports, findings, and fact sheets can be found at http://www.mentalhealthcommission.gov/reports/reports.htm

20. U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) - Numerous reports on various aspects of children's mental health services, including *The CMHS Approach to Enhancing Youth Resilience and Preventing Youth Violence in Schools and Communities and Exemplary Substance Abuse Prevention Programs* are available at http://www.samhsa.gov/

21. Zero to Three provides a variety of information on promoting the healthy development of young children at http://www.zerotothree.org/

BEST COPY AVAILABLE

State Resources

1. California's Little Hoover Commission - A bi-partisan independent state body dedicated to promoting efficiency and effectiveness in state programs. Their report, *Young Hearts & Minds: Making a Commitment to Children's Mental Health,* can be accessed at http://www.bsa.ca.gov/lhc.html

2. The Connecticut Governor's Blue Ribbon Commission on Mental Health report can be found at http://www.dmhas.state.ct.us/blueribbonreport.htm

3. Illinois Department of Human Services, University of Illinois at Chicago, and Community Behavioral Healthcare Association of Illinois. *Curriculum for Mental Health Providers: Serving Children, Adolescents and Families in Community Settings in Illinois,* March 2002.

4. The Florida Strategic Plan for Infant Mental Health is available through the Florida State University Center for Prevention and Early Intervention Policy at http://www.cpeip.fsu.edu

5. Illinois Department of Human Services. (1997-1998). *School-based/linked Health Centers in Illinois: Annual Report.*

6. Minnesota Children's Mental Health Task Force - Task Force information, including a Final Report, can be accessed at www.dhs.state.mn.us/childint/Programs/ChildMentalHealth/ms-2177.pdf

7. *Toward the ABCs: Building a Healthy Social and Emotional Foundation for Learning and Living* (2002), along with other resources, can be accessed through the Ounce of Prevention Fund at http://www.ounceofprevention.org

8. Wisconsin Council on Children and Families, *Children's Mental Health: From Parenting to Policymaking* can be found at http://www.wccf.org/publications/

BEST COPY AVAILABLE

ENDNOTES:

[1] Ringel J and Sturm R. *Mental Health Care for Youth: Who Gets it? How Much Does it Cost? Who Pays? Where Does the Money Go?* Santa Monica, CA: RAND, 2001.

[2] Illinois Mental Health for Children Working Group, *White Paper on Mental Health Services for Children and Youth in Illinois,* March 2001.

[3] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000.

[4] Centers for Disease Control and Prevention. *An Ounce of Prevention...What are the Returns?* 2nd ed., rev. Atlanta, GA: US Department of Health and Human Services, CDC, 1999; Karoly, L. *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions.* Santa Monica, CA: RAND, 1998.

[5] Karoly L., *What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions,* 1998.

[6] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General,* 1999.

[7] Shonkoff, JP and Phillips, DA. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Research Council and Institute of Medicine, 2000.

[8] Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, 2000.

[9] Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. *Prevalence of serious emotional disturbance in children and adolescents.* Mental Health, United States, 1996.

[10] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General,* 1999.

[11] Ibid

[12] Teplin LA, Abram K, McClelland GM, Dulcan MK, and Mericle AA. Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry.* 2002, 59:1133-1143.

[13] Civitas, Brio Corporation, Zero-to-Three, and DYG, Inc. *What Grown-ups Understand About Child Development: A National Benchmark Survey,* 2000.

[14] Commonwealth Institute for Child and Family Studies and the Department of Psychiatry Virginia Commonwealth University. *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness: Results of a National Survey of Parents and Other Caregivers.* Arlington, VA: The National Alliance for the Mentally Ill, 1999.

[15] Adalist-Estrin A. The Influence of Parental Mental Health on Child Development. Presentation at the Agency for Healthcare Research and Quality, User Liaison Program, *Improving Early Childhood Development: Promising Strategies for States and the Health Care System,* January 2002.

[16] Illinois Mental Health for Children Working Group, *White Paper on Mental Health Services for Children and Youth in Illinois,* March 2001.

[17] *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness: Results of a National Survey of Parents and Other Caregivers,* 1999.

[18] Weinick RM and NA Krauss. 2000. *Racial/Ethnic Differences in Children's Access to Care. American Journal of Public Health.* 90(11):1771-1774

[19] *Children's Mental Health Needs, Disparities and School-based Health Services: A Fact Sheet.* Washington, DC: Center for Health and Healthcare in Schools.

[20] *White Paper on Mental Health Services for Children and Youth in Illinois,* March 2001.

[21] Rosenbaum S, Proser M, Schneider A, and Sonosky C. *Room to Grow: Promoting Child Development Through Medicaid and CHIP.* Washington, DC: Center for Health Services Research and Policy, July 2001.

[22] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage.*

[23] *State Laws Mandating or Regulating Mental Health Benefits.* Washington, DC: National Conference of State Legislatures, July 2002.

BEST COPY AVAILABLE

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

[X] This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

[ ] This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

P20031304